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THE HOSPITAL ADMINISTRATOR: ROLE MAKING, ORGANIZATIONAL STRUCTURE AND ADMINISTRATIVE PROCESSES

by

Ⓒ G. DEWEY EVANS

A THESIS

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FACULTY OF GRADUATE STUDIES AND RESEARCH

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research, for acceptance, a thesis entitled....The Hospital Administrator: Role Making, Organizational Structure and Administrative Processes

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ABSTRACT

This study analyzed the role of the hospital administrator. Also analyzed were the organizational environments with which the administrator coped and within which he enacted his role, and the administrative processes through which the administrator coped with the power and authority systems in the hospital.

The literature was reviewed pertaining to complex organizations, role theory and the characteristics of the hospital administrator's role.

Four hospitals participated in the study. Survey questionnaires were used to obtain information about the following characteristics of the socio-technical sectors: bureaucracy, negotiation, professionalism, supervisory skills, decision-making, role conflict, role ambiguity, job satisfaction, coordination, and intra-departmental relations. Survey questionnaires were sent to medical staff, board members, administrative assistants to determine the role conceptions held by each about the role of the administrator. Interviews were also conducted with members of these groups in the four hospitals.

Eight hypotheses related to organizational structure were tested. The four organizations appeared to be normative, participative, and to have positive climates. These findings, and those of an intercorrelational analysis among the study variables, were felt to be explained by the intensive technology employed by the organizations. The data also suggested

that the bureaucratic structure and the negotiated order were functionally related, due to the nature of the technology and the positive climates.

An analysis of the specific organizational climates and administrative roles, processes and structures, revealed both similarities and differences among the four hospitals. Common to all administrators were the delegation of task areas to administrative officers, the use of feedback to maintain control, the use of committee structures to maintain coordination, and the role of the administrator as integrator and information processor. The functional reciprocity between bureaucracy and negotiation, shown to exist in the socio-technical sectors of the organization, also existed at the managerial level and served to link the managerial to the socio-technical levels of the organization.

The roles conception data and the interviews indicated that the various role senders were in greater agreement about the amount of power each group should have in traditional than in nontraditional areas.

The administrators were expected to have decision-making power in traditional areas and recommendation giving power in nontraditional areas. The conditions of multiple leadership were shown to exist, with the administrators enacting facilitating roles in the management triangle.

The administrators used the medical staff hierarchies to negotiate and influence the kind of policy and decisions that were made in nontraditional areas. The administrators' assessed stature appeared to be a function of how well they utilized bureaucratic structures for routinized negotiation. Influence was thereby obtained through these structures and by enacting their roles within the restricted role expectation of recommendation giving.

The administrative process and the administrators' ability to cope with the peculiar power and authority structure of the hospital, both with respect to the management triangle and the socio-technical sector, tended to involve a functional relationship between the bureaucracy and the negotiated order.

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CHAPTER I

STATEMENT OF THE PROBLEM: ITS IMPLICATIONS AND BREADTH

I. THE PROBLEM

This study addresses itself to the following questions: how is the role of the hospital administrator conceived by different role senders, and what effect does the context of the organization have on the structure and process of administration?

The purpose of the present study, therefore, is to analyse the role of the hospital administrator, the organizational environment with which he must cope, and the administrative process which marks an adjustment to the power and authority system of what has been called a "Prototype Organization."[1] The study is directed at what Perrow has identified as a neglected area of research in medical sociology. He has stated that:

> It is typical of medical sociology that there are scores of studies of mental hospital attendants and of nurses in general hospitals, most of which repeat one another without actually replicating each other, but almost no work has been done on hospital administrators and very little on medical-staff hierarchy and leadership. Nurses and attendants are docile, captive, and bunched into groups convenient for questionnaires. The more difficult, the theoretically more productive and challenging, and, in practical terms, the more influential studies of organizational elites have been neglected.[2]

In this study, the relationships between professionalism and bureaucracy, negotiation, formal and informal decision making modes, and role conflict and ambiguity will be explored. Data collected from four acute care institutions will be analysed in an effort to depict the organizational contexts which confront the administrators of these organizations. The extent of bureaucracy and negotiation, as well as role conflict and ambiguity, intra-departmental coordination, inter-personal relations, job satisfaction and professionalism will be determined in order to describe the organizational contexts. The type of supervision and the relationships among the organizational factors will also be determined.

It is important to depict the organizational contexts of the hospitals, since the behavior of the administrators and the administrative process are thought to affect and in turn be affected by these contexts. To study only the role of the administrator and the administrative process in isolation from this context, would ignore the systemic nature of organizations and roles.

Towards this end, general and specific analyses will be conducted of the organizational contexts of the four general acute care hospitals in the study. In addition, a general analysis of the conceptions held by physicians, administrators, boards of directors and administrative officers will also be conducted in order to clarify the role relationships of the management triangle. Particular attention will be paid to the nature of the administrator's "facilitating role" within the multiple leadership situation thought to be characteristic of the hospital organization. An analysis of the administrative process, and the relationship between bureaucracy and the negotiated order at the managerial level of the organizations will also be conducted.

In addition to studying the general patterns across hospitals, an attempt is made to describe the context of each of the sample hospitals, as well as that of the administrator's behavior within each of these contexts. This analysis will be done in order to discern what effect specific contexts have on administrators, and to pick out specific variations that occur, and which differ from, the general patterns in both the administrative processes and organizational contexts.

II. IMPLICATIONS OF THE STUDY

The focus of the present study should have theoretical and practical implications for the theory and management of organizations, and for what has come to be known as role theory in sociology. A discussion of the role-making process, and an attempt to identify some of the factors that affect this process, should help to bridge the gap between what Wilson has labelled the "Normative Paradigm" and the "Interpretive Paradigm" of role theory.[3] This may, at the same time, suggest a viable means for integrating the formal and informal aspects of complex organizations, as well as indicating how adjustments are made by both the organization and its members to the systems of power and authority relations inherent in such structures.

Further, the study has implications regarding the limitations of the distinction between a sociology of medicine and a sociology in medicine.[4] In a recent monograph, Wilson has stated that the sociologist of medicine ". . . is not, in the first instance, devoted to discovering clues to more effective care for patients," despite the medical sociologist's concern for the structure of medical care organizations.[5] Rosengren and Lefton,[6] on the other hand, clearly suggest that a better understanding of the roles in and structure of health care organizations and patient orientations will help in removing the "crisis"[7] in the organization of medical care. A lack of understanding of such organizational characteristics, they argue, is one of the primary reasons for the failure of some recent attempts at inter-organizational collaboration.

Moreover, it appears necessary to more fully understand the roles and functioning of "boundary spanning units"[8] and the organizational environments with which these units must cope.[9] Since the present study is directly concerned with the "boundary-spanning" role of the hospital administrator and the processes of adjustment he makes to his organizational environment, the project has implications for the management of inter-agency collaboration.[10]

As well, the study has implications for the management of technological change, specialization, professionalization and complexity that is increasingly characteristic of both health and non-health oriented complex organizations.[11]

III. BREADTH OF THE STUDY

Since the study is primarily focused on one particular role, it might be expected that the scope of the study would be similarly restricted. Such an approach was rejected for two reasons. First, an initial field study clearly indicated that the position of the administrator, and his functioning within that position, were affected by factors which would have been excluded in a study using a narrow perspective. Second, Parsons has suggested that organizations can be divided into three distinct levels - technical, managerial and institutional.[12] As Thompson[13] points out, organizations attempt to seal off their technological or operational[14] sectors from environmental constraints and contingencies by a number of means. This means that organizations attempt to secure a closed-system model in so far as this logic applies to the socio-technical sector of an open-system. It is the function of the managerial sector, however, to mediate between the institutional and technical sectors, and to administer or control the latter.[15] Accordingly, any study which focuses on the managerial sector, as this study does, should attempt to include the effect of the technological and institutional sectors on the managerial.

The organization of the study reflects these concerns, and especially the effect of the socio-technical sector on the role of the administrator in the managerial system.

In Chapter IV, ten hypotheses and two corollaries will be tested which explore the relationship between professionalism and bureaucracy, negotiation, decision-making modes, and role conflict, as well as the relationship between bureaucracy and negotiation.

In Chapter V, the organizational context of the hospitals will be described. Data collected from hospital personnel will be presented regarding such organizational factors as bureaucracy, negotiation, job satisfaction, intra-departmental relations and coordination, and supervisory styles. An inter-correlational analysis among these factors will follow the descriptive analysis of organizational contexts. Following the inter-correlational analysis, each of the separate hospital contexts will be presented in relation to the administrator's behavior within those contexts. The extent of bureaucracy and negotiation within each of the organizations will also be determined.

The latter concern will reflect the discussion in Chapter II of two theoretical orientations towards organizations, namely the negotiated order and bureaucracy. The pertinent literature supporting each perspective will be reviewed in Chapter II, the limitations of each discussed, and a synthesis offered. This will supplement the discussion to follow of the administrator's role in the managerial system. A review of the literature, the history and structure of the administrator's role will then be presented.

Data reflecting this discussion of the administrator's role and the role-making process will be presented in two parts in Chapter VI. The first part of Chapter VI will contain an analysis of the results from a Roles Conception questionnaire regarding the comparative functions and powers of the administrator, the board of trustees and physicians. In the second part, the results will be presented from interviews regarding the role-making and negotiation processes, as these reflect adjustments to the authority and power systems in the organizations.

Finally, a summary of the findings, suggestions for further research, and implications for organizational theory will be presented in Chapter VIII.

In summary, the problem of the thesis is to analyse the role of the hospital administrator, and the role-making and negotiation processes as these mark an adaptation to the organizational environment which confronts the administrator. In the following chapter, a review of literature regarding the structure of the hospital organization and a discussion of two theoretical orientations used to analyse these structures will be presented. This will be followed by a discussion and review of the literature regarding the role of the hospital administrator in these organizational structures.

FOOTNOTES

1. Alan D. Bauerschmidt, "The Hospital as a Prototype Organization," *Hospital Administration*, (Spring, 1970), pp. pp. 6-16.

2. Charles Perrow, "Hospitals, Technology, Structure and Goals," *Handbook of Organizations*, ed. James G. March, (Chicago: Rand McNally, 1965), p. 953.

3. Thomas P. Wilson, "Conceptions of Interaction and Forms of Sociological Explanations," *American Sociological Review*, 35 (August, 1970), pp. 697-709.

4. Robert Strauss, "The Nature and Status of Medical Sociology," *American Sociological Review*, 22(April, 1957), pp. 200-204.

5. Robert N. Wilson, *The Sociology of Health: An Introduction*, (New York: Random House, 1970), p. 1.

6. William R. Rosengren and Mark Lefton, *Hospitals and Patients*, (New York: Atherton Press, 1969). See especially Chapters 5, 6 and 8.

7. W. Richard Scott and Edmund H. Volkart (eds.), "Introduction," Medical Care: *Readings in the Sociology of Medical Institutions*, (New York: John Wiley and Sons, 1966), pp. 1-4.

8. James D. Thompson, *Organizations in Action*, (New York: McGraw-Hill, 1967), p. 70 and pp. 110-112.

9. Sol Levine and Paul E. White, "Exchange as a Conceptual Framework for the Study of Interorganizational Relationships," *A Sociological Reader on Complex Organizations*, ed. Amitai Etzioni, (2nd. ed.; New York: Holt, Rinehart and Winston, Inc., 1969), pp. 117-132.

10. Rosengren and Lefton, *op.cit.* p. 185.

11. Bauerschmidt, *op.cit.* pp. 13-14.

12. Talcott Parsons, *Structure and Process in Modern Societies*, (New York: The Free Press of Glencoe, 1960).

13. Thompson, *op.cit.* pp. 19-24.

14. Rosengren and Lefton, *op.cit.* pp. 173-189. Unlike Thompson, Rosengren and Lefton point out that the operational sectors and administrative sectors may have different degrees of contact with similar levels in other organizations. This contact may be forced or voluntary, but because of the different levels and types of contact, this contact will have

different effects on the effectiveness inter-agency collaboration and the structure of each organization. Cf. Michael Aiken and Jerald Hage, "Organizational Interdependence and Intraorganizational Structure," American Sociological Review, 33 (December, 1968), pp. 912-132.

15. Thompson, op.cit. pp. 10-11.

CHAPTER II

THE HOSPITAL AS A BUREAUCRACY OR NEGOTIATED ORDER

I INTRODUCTION

As stated in Chapter I, the first aim of this chapter will be to review two perspectives[1] that have been used in analysing formal and complex organizations,[2] and in particular, the hospital in North American society. The immediate concern will be to discuss the nature and bases of the peculiar authority structure of the hospital, and to point out some of the difficulties that this authority structure poses for the organization and its members. Attention will then be turned to technology, a neglected variable in sociological studies of the hospital. The importance of this variable, and its effect on professionalism, control, decision-making techniques, and the bureaucratic structure of the hospital, will be discussed. Next, the concept of the negotiated order will be discussed; its limitations and advantages noted. Following this, the two models of organizations will be synthesized, in an effort to describe how the hospital administrator functions in his position, vis-a-vis the board, medical staff and the technical sectors of the organization.

II. THE BUREAUCRATIC MODEL

The Weberian Model[3] or the bureaucratic model of organizations has been used extensively in the analysis of general, acute-care hospitals.[4] As Perrow has pointed out, the use of such a conceptualization by social scientists has been instrumental in typifying the organizational structure of general hospitals as a deviant type.[5]

Specifically, this apparent deviance stems from the dual authority system in the hospital.[6] This duality, in contrast to the unitary line of command which presumably exists in other organizations, creates the flexibility and many of the problems that are associated with the hospital organization.[7] It is also instrumental in partly defining the role of the hospital administrator, as well as those of other hospital personnel.

This duality stems from the different bases of authority that exist within the organization, namely the functional (expertise or charismatic), and administrative (or positional), of which the usual examples are the medical staff and the administrator.[8] Rizos suggests that there are many other centers of functional authority besides that of the medical staff, (such as nursing administration, laboratory, x-ray, etc.) which serve to complicate the attainment of organizational objectives.[9]

Differences in bases of authority, of course, imply differences in training, ideologies, identities, competencies, and knowledge. These differences in social attributes contribute to the difficulties in achieving goals and coordination, and in finding common, acceptable solutions to problems which involve personnel from the different functional components of the organization.[10] Furthermore, since the bases of authority differ, the members of the organization are differentially, and preferentially, oriented to one or the other source of authority. Some groups, such as nursing personnel, may of course find themselves oriented to both sources and for different reasons.[11]

If each unit of the hospital could function independently, the dual authority system would pose little difficulty. This is not the case, however, since the provision of patient care demands the interdependency and integration of the various organizational units,[12] and administrative concerns often overlap with functional concerns and vice versa. In this sense, the hospital represents what Becker and Gordon identify as an "internally coupled bureaucracy" characterized by a high degree of "functional decentralization."[13] That is, the administrative component is typically in the service of the functional units, while at the same time being responsible for the overall integration and coordination of these functional components. These functional components, however, tend to operate in a semi-autonomous fashion with regard to their "tasks" (often defined as being of a professional nature, which serves to justify their claim for autonomy).[14] Furthermore, each of these departments have professional heads who must coordinate and perform those administrative tasks which are involved in the internal operation of each of these departments.

This line of reasoning is equally applicable to the medical staff, who find that medical and administrative concerns often intertwine (i.c. scheduling of surgery), and that the organization of the medical staff is as much an administrative matter as it is a medical staff concern.[15]

The dual authority system is one factor in the development of multiple control and authority structures. It is the recognition of these multiple control structures within a single organization, however, and of the reasons why these multiple structures develop, that force the investigator to take a divergent stand from most of the available literature on hospitals.

Most authors, when discussing the organizational structure of the hospital, either explicitly or implicitly suggest that, if a unitary line of command could be developed, many of the problems in control would disappear. A few resign themselves to the hospital's peculiar structure, because they recognize that the professional and semi-professional type of employee will continue to be characteristic of hospitals, and therefore, so will the dual authority system and the problems associated with professionals. Unlike Bauerschmidt,[16] and Perrow,[17] few recognize the importance of technology as a major factor in defining the organizational structure, nor the variation in this factor throughout the organization. Little is said about the related variations in complexity, differentiation, bureaucratization, professionalization, and the centralized-decentralized departmental structures associated with hospitals.[18]

The dual authority system may defy the logic implicit in the ideal type Weber described.[19] Nevertheless, it is because of this peculiar organizational structure, developed around a particular technological core, and not in spite of it that the hospital has been as successful in treatment as it has been. What is required, then, is a more appropriate strategy for analyzing the organizational structure of the hospital, rather than relying solely on the typical approach based on the deviant dual authority system model.[20]

One such strategy is to view organizations as multi-group systems which utilize both open system and closed system logics. Furthermore, an important determinant of organizational behavior and structure is the type of technology employed.

Technology and Social Structure[21]

As Perrow has pointed out, technology is a factor that has been consistently ignored in the analysis of the structure of the general acute care hospital. He defines technology as "...the actions that an individual performs upon an object, with or without the aid of tools or mechanical devices, in order to make some change in that object."[22] This definition, however, raises a number of issues and difficulties, especially when technology is considered as an independent variable affecting social structure. The most difficult problem is specifying precisely what elements are to be considered part of technology. As Perrow indicates:

> The distinction between technology and structure has its gray areas, but basically it is the difference between an individual acting directly upon a material that is to be changed and an individual interacting with other individuals in the course of trying to change that material.[23]

Perrow clearly distinguishes between technology, and task and social structures including in task structure such concepts as control (discretion and power) and coordination (planning or feedback). He considers technology to be composed of at least two aspects: (1) search processes, both those that are logical, systematic and analytical, and those that are unsystematic; and (2) the number of exceptional cases encountered in the work.

Thompson provides further clarification when he describes the type of technology employed by the acute-care institution as "intensive," in contrast to "mediating" or "long-linked" technology. That is:

> ...a variety of techniques is drawn upon in order to achieve a change in some specific object; but the selection, combination, and order of application are determined by feedback from the object itself. When the object is human, this intensive technology is regarded as "therapeutic," but the same technical logic is found also in the construction industry.... The intensive technology is a custom technology. Its successful employment rests in part on the availability of all capacities potentially needed but equally on the appropriate custom combination of selected capacities as required by individual case or project.[24]

Thompson's statement must be regarded as a broad generalization of the type of technology employed in the hospital as a whole. Within particular segments of the hospital, for example, routinized, low discretionary, highly predictable task structures are more likely to lend themselves to long-linked technologies. That is, individual tasks are linked together in such a way that the completion of one task is dependent upon the completion of some previous tasks. The techniques employed (i.e. surgery and drug therapy) are therefore part of technology. While the characteristics of the task structure (i.e. the degree of discretion regarding the use of different therapies) affect and are affected by the technologies employed and available, the distinction between the two should be maintained as much as possible.

A discussion then, of the concepts of discretion, predictability, routinization, and uncertainty, would appear to be necessary at this point in order to clarify the effect that technology has on organizational structures.

In a study of sixteen health and welfare agencies, Aiken and Hage found that discretion was not related to the routineness of work.[25] The routineness of work, they argue, refers to the variety there is in the job. Bell, on the other hand, makes a distinction between the predictability of work demands, and discretion. Predictability, he says, "...refers to the extent to which unexpected events confront an individual while he is performing his job." It is a determinant of discretion, which Bell defines as "...judgement, choice, or selection among alternatives in order to carry out ...tasks."[26] Discretion is directed towards one or a combination of three aspects of task performance, namely, which tasks to perform, which methods to use, and in which sequence to perform those tasks.

Furthermore, Bell points out that Litwak's distinction between uniform and non-uniform tasks must be kept separate from the predictability of tasks. He states that "...Litwak's concept of uniform work tasks evidently refers to the activities actually performed by the employee, whereas predictability ...refers to the work demands which confront the individual."[27] Bell sees the degree of management control (closeness of supervision and rule usage) and the degree of professionalization as determinants of discretion.[28] For example, in his study of hospital employees he found that management control was negatively correlated with discretion, while professionalism was positively correlated with discretion. Perrow further points out that individuals may have discretion with regard to their task, but lack the power to influence policy and resource allocation decisions.[29]

It may be seen, then, that an individual may be confronted by unique (unpredictable) needs or situations, but may handle these situations in a routine manner - once he has decided (used his discretion) on which method to use (i.e. diagnoses and treatment of disease or injury). The degree of "uncertainty" associated with decision-making regarding the sequence of tasks and the methods to be used varies situationally.

As argued above, since technologies of various types are distributed differentially throughout the organization (horizontally and vertically), it would follow that the degree of routinization and predictability of tasks, type of management control, professionalism, organizational power, and discretion, would tend to be similarly distributed.

For example, Thompson points out that "...the organization's need for discretion is differentially distributed within the organization..."[30] Crozier also indicates that those individuals who must handle uncertainty are accorded the discretion and power to influence policy decisions,[31] and that as the specialist "rationalizes" his task (i.e. makes it more predictable, routine, and subject to rules) he tends to lose power. It is this loss of power of the medical staff, due to the increasing rationalization and specialization of their tasks, that Perrow found in a case study of a general hospital. Perrow, however, gave greater weight to the increased differentiation that occurs concomitantly with the increasing sophistication of medical technology. The resulting need for someone to integrate these services he saw as a factor in the administrator's increase in power.[32] Becker and Gordon have made a similar observation.[33] The lack of available technology in managing a complex and highly differentiated organization, and the uncertainty associated with the hospital's external environment have been other key factors in the administrator's increase in power.

Some of the techniques that are drawn upon in the provision of health care, are routinized, low discretion, low uncertainty, and highly predictable tasks. These tend to be the "hotel-type" tasks such as maintenance, dietary, housekeeping, and includes some administrative tasks such as accounting. Where work is routine, organizational structures tend to be more centralized, more formalized, have less professionally trained staff, and coordination occurs by planning and programing rather than by feedback.[34] Where work is predictable there is closer supervision, higher rule usage, and less professionalism and discretion.

In other sectors and levels of the organization, however, tasks are less easily routinized, are more unpredictable, uncertain, and are more discretionary. It is reasonable to expect, then, that as these factors and the technologies employed are varied, so would the type of structure. Coser's analysis of a surgical and a medical ward clearly suggests such an argument.[35] Due to the tempo and emergency character of the work, the authority structure was more centralized on the surgical ward than on the medical ward. While decision-making on the medical ward was consensual, nursing staff had more routine tasks and less discretion than nurses on the surgical ward, who were less "ritualistic" than medical ward nurses. Coser's comparison of a chronic-care hospital and a rehabilitation center followed a somewhat similar secondary analysis.[36]

We may expect nursing care units to vary in the degree of discretion, predictability of work tasks, and other factors, hence also in the extent of professionalism, centralization, formalization, and type of control (i.e. rules vs. supervision vs. self-control or collegial control). However, it is necessary to recognize that, in general, nursing staff are more similar to social workers than to physicians. That is, as Scott has indicated, social work is a "weak" profession in that it does not have the recognized ability to make the necessary task decisions to achieve a desired goal or end state. Supervisory direction, as opposed to a "colleagial" structure based on the recognized right of the individual practitioner to make independent decision, is an accepted facet of the social worker's environment.[37] Social workers and nursing staff are subject to a high degree of management control. Furthermore, not only are nurses subject to greater "observability" than other health professionals, but they must expect and accept task directives from others which, in effect, limits their recognized capacity to make independent, task-related decisions.[38]

Physicians occupy a unique position with regard to the organization, as many analysts of the hospital scene have recognized. They are a very distinctive "guest" in the organization.[39] While their dependency on and activity within the organization have increased, they and their staff organization are rarely shown on an organization chart.[40] Despite this, and unlike other production organizations, it is the physician who performs the "dirty" work of the organization. No other organization has "...staff performing front-line production or processing tasks. Usually, such staff stand in an advisory capacity to production levels."[41] Nor are there any other organizations where those who initiate and perform the "primary task" of the organization stand outside of its line of control. Nevertheless, the physician has a powerful and pervasive influence on the hospital, as Smith indicates when he states that:

> ...at the staff level, the physicians do not act merely in a passive advisory capacity. They intervene actively and powerfully throughout the structure, exerting power upon hospital operating personnel, defiant of administrative regulation, and where they are members of the boards of trustees, are able directly to control "top management" itself.[42]

The physician's unique position is due, in part, to his powerful medical association, but also to the type of task which he performs. As indicated earlier, the physician's task has become increasingly routinized, specialized and rationalized. While his "observability"[43] and dependency on the hospital in order to practice have increased accordingly, the life and death quality of his decisions has not decreased. Nor has the unpredictability of work demands and the "uniqueness" of the materials with which he works. He must still exercise considerable discretion with regard not only to diagnoses, but to the determination of the mix of curative technologies he will employ. It is also important that the relatively high degree of uncertainty attached to this process of diagnosis and treatment be recognized as contributing to the power and influence the physician retains, irrespective of the fact that medicine itself has become more highly rationalized.[44] It is through the decisions of this organizational sector that the diverse technologies located throughout the hospital are combined into an intensive technology and made operative.

These characteristics combine to create a peculiar organizational structure that is both bureaucratic and yet non-bureaucratic. The investigator would agree with Rosengren and Lefton when they state that:

> While it is essential to make the assertion that a hospital is more than just a bureaucracy, we may have to acknowledge that it is necessarily one form of bureaucracy in a highly elaborate technological form.[45]

As indicated above, the organizational structure of the hospital represents an internally coupled bureaucracy that is highly differentiated and decentralized; that is, a relatively high degree of autonomy exists across organizational units, especially in the professional and semi-professional sectors. As Becker and Gordon argue, the administrative segment of the organization, which includes all service units, is in the service of and internally coupled with the medical staff organization. This forms what Becker and Gordon further specify as an enucleated bureaucracy, since, while resources are stored, procedures are not, and cannot be specified by the administration.[46]

While there is a relatively rigid hierarchy that forms the medical staff organization, this organization tends to function on the basis of what Goss has termed an "advisory bureaucracy." As Goss points out in her discussion of clinic physicians:

> ...the hierarchy of positions entailed two different types of control relationships that varied according to whether the area of work was professional or adminis-

> trative in nature. Only in the realm of administration did the supervisory hierarchy refer to a set of formal authority relationships, that is, to the right to make decisions with which subordinates have an obligation to comply. In the realm of professional work, the hierarchy referred to formal role relationships that are most properly termed advisory, that is, the right to give advice that subordinates are obliged to take under critical review, but not necessarily to follow in making their decisions.[47]

It is important to point out here that similar patterns are likely to occur among those sectors and levels of the organization where tasks and technologies similar to those confronted by physicians tend to occur, and where highly professionalized employees of the hospital are also likely to be found. These would include specialists in laboratory, radiology and other clinical specialties, including nursing.

This advisory bureaucracy, which functions as a collegial body, serves as a social control mechanism to enforce the ethics of the professional body, as well as the quality of work done. While the administrative components of the organization can specify procedures regarding administrative matters, although constantly in danger of being accused of impinging on professional concerns, it cannot specify the procedures to be used regarding the tasks with which the professional is concerned. It is also worthwhile to point out here that the "advisory bureaucracy" is externally coupled with outside organizations which do set standards and procedures (i.e. medical schools and accrediting agencies). The medical staff organization is similar to the construction industry in this regard.[48] The medical staff reserves the right to specify and enforce procedures, while expecting the administration to provide the resources.

In summary, then, the hospital represents an enucleated bureaucracy, that is composed of two internally coupled structures, that is, the service-administrative component and the medical staff organization. Furthermore, the service-administrative component is highly differentiated, complex and decentralized. The medical staff organization in turn is highly differentiated and hierarchically arranged, but tends to function in a colleagial pattern, and is in turn externally coupled to outside professional groups which specify procedures for the colleague group. As the investigator has argued, this peculiar organizational structure of the hospital, which is both bureaucratic and non-bureaucratic, is a function of the technology employed and is not solely due to a dual-authority system.[49] The latter exists because different types of task structures, techniques, and personnel must be merged in an organization that employs an intensive technology in the provision of patient care.

Hospital Organization: Professional or Bureaucratic?

One problem remains to be discussed with regard to the hospital as a bureaucracy. That is, to what extent is the hospital a bureaucratic or professional organization, and how are these two types of organization reconciled with each other?

Litwak suggest the use of three distinct models to analyse organizations, namely the Weberian Model (for organizations performing uniform tasks), the Humans Relations Model (for non-uniform tasks), and the Professional Model for organizations performing both uniform and non-uniform tasks.[50] The typification of the organizational segments as either Weberian, Humans Relations or Professional clearly recognizes the variation in emphasis on tasks performed and the technologies used, as well as giving recognition to the horizontal and vertical differentiation that occurs. This method, however, would be too cumbersome to use for describing the whole organization, and would result in a fragmented view of the organization and how it operates.

Hall, following Litwak's suggestions, has documented the fact that organizations vary inter-organizationally and intra-organizationally in the extent to which they are bureaucratic.[51] Organizations also vary on the different dimensions of bureaucracy.[52] Furthermore, variations apply not only to the organization as a whole, but to its various segments and levels. That is, organizations are composed of horizontal and vertical segments, and each segment varies in degree on the separate bureaucratic dimensions. Hall therefore "...assumes that each of the bureaucratic dimensions... does in fact exist along a continuum and that these are measurable continua."[53]

This procedure permits a description of the organizational structure in terms of the degree of bureaucracy each of the functional (or horizontal) segments displays, as well as the variation among the vertical levels. For example, in describing the technical level of the organization one would predict that those functional segments concerned with "hotel" type functions (e.g. dietary, housekeeping, stores, laundry, and others) would be more bureaucratic than nursing administration, which in turn would be more bureaucratic[54] than most paramedical services, such as radiology and laboratory. The specificity of the description can be increased by including the vertical dimension as well.[55] One would expect the upper levels of the paramedical division to be less bureaucratic due to professional personnel and tasks requiring high discretion, while the lower segments would be more bureaucratized due to the performance of routine tasks. In comparing this description of the paramedical divisions with nursing administration one finds a distinct contrast. Due to the nature of the tasks performed, one would expect the middle levels (i.e. registered nurses) to be less bureaucratic than the upper administrative and the lower worker levels (nursing aides, orderlies) which perform relatively routine and standardized tasks.[56] One would expect that the degree of professionalism and bureaucracy would vary by nursing care units as well, for the reasons discussed earlier (e.g. surgery wards, medical wards, and intensive care units).

Following Hall, it is expected that higher levels of bureaucracy would be associated with lower levels of professionalization. As Hall and Engel point out, however, there is no need necessarily to assume an inverse relationship, since some aspects of bureaucracy may compliment, if not support, elements of professionalism.[57] Furthermore, the two dimensions are independent, although both are clearly affected by technology.[58] Bell also indicates that, despite high professionalism, the organization may force various forms of management control on such professional personnel as nursing staff.[59] This is done to ensure some degree of rationality, although it may be of a pseudo-rational nature.[60] While one may expect nursing staff to be professionally oriented, they may also be expected to experience some bureaucratic constraints. As Rosengren points out, "This is likely because those who enact determinate roles are called upon to perform specifically prescribed tasks in specifically articulated ways."[61]

These traits and variations, furthermore, have implications for the structure and functioning of the organization as a whole. As has been pointed out by Thompson and Bates,[62] functional differentiation is extreme in the hospital and exhibits a considerable degree of "hierarchical differentiation," particularly in some segments such as nursing administration. Accordingly, the "shape" of the organization tends to be both "tall" and "flat." Meyer shows that hierarchical differentiation is associated with a proliferation of supervisory levels, decentralization of authority to make decisions, and formal rules "that partly determine decisions in advance."[63] Functional differentiation is associated with the delegation of decision-making authority to department heads, where such authority becomes centralized, and with the lack of rules which permits top managers high discretion in making decisions.

The extent to which decision-making is centralized or decentralized is likely to vary with the extent of professionalism. Aiken and Hage show that, where routine work is performed, there is greater centralization, formalization, and fewer professionally trained staff. They also show that the extent of participation in the determination of organizational policy, and decision-making about the allocation of organizational resources, are positively and strongly related to the number of occupational specialties and highly trained (i.e. professional) staff. They state that:

> "An organization that has wide participation in decision-making is also likely to have less job codification, less rule observation, more professional training, and more professional activity. The organization is also likely to have less reliance on the chain of command, that is, as participation in decision-making about organizational resources increase, the job occupants are more likely to have greater control over their own work decisions.[64]

Bell's study of hospital employees tends to confirm these relationships between unpredictable, non-routine work and high professionalism, discretion, and lack of close supervision.[65]

With the increase in horizontal and vertical differentiation, professionalization, complexity, and size of hospitals that have occured concommitantly with the increase in sophistication of medical technology, problems of integration, control strategies, and modes of decision-making have also tended to proliferate and change.

Meilecke has indicated that integration of the professional into the organization is an "immediate and real problem" that must be solved. Meilecke states that:

> The potential for severe integrational problems which are posed by the differential commitment of various hospital personnel is increased by the inadequacy of the integrative mechanisms usually available to the administrative level of an organization. The control of conflict between role obligations which is normally effected by the contract of employment, for example, has varying degrees of effectiveness relative to different professional personnel but does not likely approach the degree of effectiveness for any of the professions or paraprofessions that it does relative to non-professional personnel.[66]

Not only is the professional oriented towards functional as opposed to administrative authority, but he demands autonomy and freedom from bureaucratic controls. These characteristics pose severe integration and coordination problems for an organization employing intensive technology and whose "primary task" requires considerable interdependency and inter-coordination of its units.

The hospital wide mechanisms for integration which Bauerschmidt proposes, that is, that consultation (organic or colleagial structures) should replace order-giving (bureaucracy), do not seem possible.[67] Professionals often work side by side with non-professionals and colleague-like relationships do not usually develop between these two types of personnel.[68] Order-giving occurs concommitantly with consultation, and it is likely that the latter is able to occur because the former exists. Nor does consultation completely explain how the differentiated services and specialized units, located throughout a structure as complex as the hospital, are brought together. Only a bureaucratic system is able to provide an efficient solution to this problem in human organization. Furthermore, the types of controls available to the organization differ by the type of occupation, as do the bases of compliance. Changes in technology force changes in the techniques of management that are employed.[69] Following Thompson and Tuden,[70] decision-making situations and strategies will tend to vary across the various horizontal and vertical segments of the organization, as does the extent of such things as professionalism and bureaucracy. These variations in decision-making strategies and control techniques will not only be determined, in part, by the organization's environment, but very importantly by the nature of the task and technologies employed.

In summary, the bureaucratic order serves to explain, in part, how the hospital organization tends to function. Of particular concern is the fact that it seems not to be a completely adequate explanation.

III. THE NEGOTIATED ORDER

Strauss and his colleagues have also indicated a dissatisfaction with previous models or conceptualizations for analyzing hospitals.[71] The model they propose is "grounded upon minimal consensus" or "working agreements," that are arrived at by a process they label "negotiation." The resulting conception of the organization, and its basis for continuity and change, is an "order" that is based on agreements which are always subject to renegotiation.

Negotiated agreements may exist in the form of concrete roles or contracts, or in abstract forms such as tacit understandings. They may also vary in terms of duration, clarity, type and frequency among various types of personnel. One would expect that such agreements will vary with the type of situation and will have a "history."[72]

Negotiation is a term that Strauss does not define, although a number of synonyms are given, such as bargaining, politicking, persuading.[73] He relies more on what Nettler calls "explanation by definition" to define the term.[74] Bucher comes closest to a definition when she says that "...such interactions can be called negotiation because what is at issue is not just what will be given to the faculty member, but what he is to give in return."[75] Strauss implies, as well, that negotiation is a process in which alternatives are presented until some action alternative is found that is agreeable to both parties. Accordingly, negotiation is a form of interaction involving an "exchange" of rights and duties and couched in terms of a "bargaining" relationship. In this regard, Bucher points out that "role-creation" and negotiation are "...two sides of the same coin: when one is present so is the other."[76]

This raises three important observations regarding the conception of organizations as "negotiated orders." First, this focus on the negotiatory process places greater weight on "emergent" properties than it does on properties that have been stabilized (institutional as compared to the subinstitutional). As a consequence, this particular emphasis will result in a repudiation of other approaches that are directed towards that which is relatively stable. Bucher, for example, found that in her study of a medical school, "Authority as a concept has relatively little heuristic value in this setting."[77] Strauss further argues that status in other researchers' formulations determines roles and prescribes behavior, but in his own "...sets the problems to be solved through negotiative interaction."[78]

There is some convergence here with other critics of role theory, such as Turner,[79] Wilson,[80] and Rushing,[81] who find the prescriptive or "normative" nature of such theory not to be entirely accurate.[79] Wilson proposes an "Interpretive Paradigm" which would account for the "emergent," "non-institutionalized" character of some interactional settings and relationships. Yet, neither he nor Turner are prepared to completely ignore the "normative" approach. It would appear, therefore, that some concessions must be made to both the normative and the interpretative aspects of role theory. This requires a specification of the conditions under which negotiation will and will not occur. This is compatible with Strauss's formulation, since even he recognizes that negotiated agreements have some duration or history which binds the organizational actors into a sequence of "normative" or prescribed behaviors, even though he emphasizes the continuous reconstitution of such orders.

The second observation relates to the use of the concept of negotiation on at least three conceptual levels. That is, negotiation is used to explain the process of segmentalization of a professional body, the formation of "coalitions"[79] or parties within an organization over some "issue,"[80] and finally, at an interpersonal level where two actors come to some agreement as to what role each will play in some situation.[81] The concept of "negotiation" is indeed parsimonious for it describes what seems to be similar kinds of processes at three distinct levels. To use the concept interchangeably at all three levels, however, makes it loose and ambiguous as to what processes are occuring and at which level. Furthermore, the kinds of negotiated agreements and procedures by which agreements are reached are not entirely similar at each level and should be kept distinct. Accordingly, the three levels should be distinguished as institutional negotiation, coalition negotiation and interpersonal negotiation, respectively.

Bureaucracy and Negotiated Orders

The third and final observation emphasizes organizational processes. Strauss's model was intended to explain "...how a measure of order is maintained in the face of inevitable changes," and to explain that activity which is not explained by the formal or informal structures.[82] While succeeding at the first task, the model fails at the second because it does not give sufficient attention to the impact of technology, nor to the variation in bureaucratic elements, that can occur throughout an organizational structure

The model, Strauss argues, is applicable if an organization utilizes personnel trained in different occupations; or if each occupational group contains individuals trained in different traditions, who emphasize different values and philosophy, and if some personnel are professionals.

The first difficulty in following these suggestions is that one is faced with determining when the negotiatory model is appropriate and when the Weberian or bureaucratic model is more appropriate. It will be recalled that this is the same problem encountered with Litwak's proposal. Bucher, for example, argues that:

> Another major point about organization within the college is that more than one organization is operating in conjunction with it. A basic distinction that aids analysis here is whether the coexisting forms are located within the fabric of the academic organization or outside of, and coterminous with, the academic organization.[83]

Modern systems theory indicates that to ignore the systemic quality of organizations results in a bias in describing the operation of even relatively remotely connected units of an organization (e.g. research and development). In Bucher's study we find a non-academic organization, that is highly bureaucratic and clearly (although we are given no indication as to how), attached to and affecting the operation of "...two types of coexisting organizations within the academic organization," namely the clinical departments and the basic-science faculty. Such an approach raises the question of what criteria to use in differentiating where one organization begins and the other leaves off, or even if separate organizations exist. The functional differentiation of many modern complex organizations should not necessarily be interpreted as meaning that separate but coterminus organizations exist. Separate functional sectors of an organization, one highly bureaucratic, the other professional, may operate within the boundaries of a single organization. Indeed, as is the case with the modern hospital, neither may be able to operate effectively without the other. Bucher's and Litwak's approach to organizations would result in a fragmented view of any organization, rather than in a concern for the operation of the whole organization.

It is also possible that a segmental approach to complex organizations, and "saturating"[84] one's sample with cases of a particular type, results in a neglect of observations of other organizational segments which do not function on the basis of a negotiated order. Furthermore, the possibility that negotiation and bureaucratic elements tend to occur together may be overlooked if the organization is not considered as a whole. A continuum that permits the researcher to identify components of an organization as more or less professional or bureaucratic than other components, would force the researcher to consider the possibility that bureaucracy and negotiation are not mutually exclusive forms of organizational behavior. Such an approach might also provide the criteria for defining the boundaries of different sectors of the organization.

Bucher's argument that authority is of little use in the setting she analyzes ignores the distinctions in the types of authority made by Weber, and by other relevant studies such as those by Goss.[85] It would seem reasonable to expect that functional and administrative authority operate within professional settings, although as Goss indicates, under different situations. The importance of "assessed stature" in Bucher's analysis, which operates under different situations and affects the ability to negotiate successfully, and the associated concept of professional identity, seem to converge with Goss's analysis. Following this logic, then, the negotiated order and the bureaucratic model may not necessarily be alternative conceptualizations but complementary processes. Both may be relevant within an organization that is complex and which permits variations in technology, bureaucracy and professionalism throughout the various sectors and levels of the organizational structure.

Furthermore, while the work of Bucher and Strauss de-emphasizes the bureaucratic elements of the organizations which they studied, it is nevertheless apparent that the vertical dimensions, and the positions held within the organization, affect the negotiatory processes. While the relationship between the head of a department and the professional staff may not be based predominantly on administrative authority, the professional staff must still cope with the powers that are inherent in the position of the head of department, irrespective of who occupies it and his assessed stature. In addition, position in the hierarchy influences the extensiveness of the role-set of the position occupant, although, as Bucher points out, the assessed stature of the position occupant is an important and independent variable.

Technology and Negotiation

A final limitation placed on the holistic use of the negotiatory model, is the oversight in not recognizing the influence technology has on the negotiatory process, nor its effect on the structure of an organization. Friedson recognizes this limitation when he states that:

> The organization of mental hospitals can vary so markedly because there is no clearly efficacious method of "curing" the mentally ill. It seems precisely the varied ideologies and technologies of psychiatry, and its extraordinary therapeutic uncertainty that permitted the existence of the unstructured situations studied by Strauss and his associates. ...In contrast, a surgical ward such as was studied by Coser is likely to vary considerably less in its organization for its stable and frequently standardized therapeutic technology sets distinct limits on the degree of negotiation that can take place among the staff without interfering with the functional goals of the organization. Much the same regular and stable organization of authority and specialized task is likely to exist from one ward or hospital to another in such a case.[86]

While Strauss argues that rules are negotiated, it is difficult to see how this would apply to rules that are determined by an effective technology. Furthermore, the availability of a specified technology is likely to determine, to a fairly large degree, the kinds of roles and content of roles that exist. In such situations, negotiation may occur over areas of uncertainty, such as the diagnoses of chronic illnesses, but not regarding the treatment techniques themselves nor the resulting behavior and rules.[87] Organizations attempt to rationalize such areas in an effort to reduce uncertainty, and are able to succeed because of existing technologies. On the other hand, in situations where there is "no one best way," where there are alternative modes to some desired end state, negotiation is most likely to occur. Accordingly, negotiatory behavior is most likely to occur in certain segments and levels of an organization and to a lesser degree in others due to the availability or lack of effective technologies, the type of tasks performed and the type of personnel involved.

IV. THE HOSPITAL ADMINISTRATOR: HIS ROLE AND POSITION WITHIN THE ORGANIZATION

Having described the nature of the technical sector of the organization and the concept of the negotiated order, it becomes appropriate to discuss the managerial and institutional sectors relative to the technical. Because of the importance of the technical sector as a socio-technical task environment for the administrator, it has been necessary to explore it in some detail. The importance of this sector in defining the administrator's role is clearly indicated in most *contemporary* definitions of the administrator's role, of which the following is one example:

> The hospital administrator is the person appointed by the board to integrate and coordinate the business of the hospital. The administrator acts in an over-all executive capacity. He is directly responsible for the conduct of all internal affairs.[89]

A number of writers[90] have indicated, however, that this definition has not always described the administrator's role. The administrator's functions have shifted from purely budgetary concerns to those associated with a responsibility for the integration and coordination of the diverse occupational groups and activities which have been brought into the hospital since World War II. And there is some reason to expect that the administrator's role will expand in the future to include the function of integrating the community and the hospital.[91]

A number of factors account for these past shifts in the administrator's role and the future direction the role may take. Perrow points out that:

> Administrative dominance is based first on the need for coordinating the increasingly complex, non-routinizable functions hospitals have undertaken. There is an increasing number of personnel that the doctor can no longer direct. The mounting concern of trustees, doctors themselves, patients and pre-payment groups with more efficient and economical operation also gives the administrator more power.[92]

Perrow also indicates that the hospital has had to cooperate with an increasing number of specialized and interdependent community health service agencies, and has had to increase its external contacts with outside agencies and professional groups. The administrator has been partly responsible for the development of these external linkages and has the training necessary to cope with the problems such systemic linkages entail.[93] Furthermore, the physician himself has become increasingly dependent on the hospital,[94] while the trustee has tended to withdraw from the hospital leaving the day-to-day operation of the hospital in the hands of the administrator. While trustees make policy, they often depend on the administrator for the advice and information necessary to make policy decisions.

These factors have been instrumental in increasing the administrator's power, relative to that of the medical staff and the board of trustees, and expanding the "radius" of the administrator's role.[95] It is noteworthy that these adaptations to the flux of the power structure at the managerial level are a consequence of forces emanating from both the institutional and the technical sectors of the organization. Other changes that appear to be in an embryonic state in the hospital, and in the administrator's role, seem to originate more from the institutional sector than from the technical. These external pressures may increase the administrator's "external orientation."[96] As Meilecke pointed out in 1963, the "long-term and emergent" problems of goal-attainment and adaptation are precisely those pressures originating in the institutional sector today (i.e. economic and governmental pressure, integration of the hospital with community health agencies, development of the hospital as a "health center").[97]

The "immediate and real problems" for the hospital and its administrator, however, have been those associated with the internal operation of the hospital. These "problems" have been the major forces so far in shaping the administrator's role, and are likely to continue to do so until solutions can be found that permit the "rationalization" of the management or administrative process.

The Conflict Between Professional and Administrative Authority

While the administrator's power has increased, the role of the administrator has not been made any easier to perform. Like most other roles in the hospital, it has been extended.[98] With the increase in the number of professional departments, the administrator has found his "span of control" increasing and his administrative responsibilities over professionals expanding. Despite these expanded responsibilities, and the board's delegation of administrative authority to him for the daily operation of the hospital and integration of professional activities, the administrator finds himself in an anomalous position with regard to these professionals within the organization. With the increasing functional differentiation, the administrator has delegated authority to professional heads of departments who are accountable to him as an administrative superior, but not as a professional superior.

As Cordes has pointed out, the administrator is faced with a growing proliferation of distinct occupational and professional groups who find:

> ...it most comfortable to cooperate with members of their own specialty system. While persons highly skilled in technical knowledge may achieve horizontal cooperation with other specialists in the organization, they find it very difficult to conform to the expectations of those who constitute the hierarchical authority in the hospital.[99]

Like the medical staff, these professionals are oriented more towards functional authority, and because of their expertise, claim the authority and autonomy to regulate themselves within their own spheres of competence. They are, therefore, less likely to "validate" a superior-subordinate relationship with the administrator. He is likely to find, therefore, that his directives and communications are either ignored, or his authority questioned as an intrusion upon matters that are defined as relevent to "professional" domains and not administrative concerns. As Tappan points out, the administrator:

> ...is much more likely to be a professionally trained manager, attempting to arbitrate among conflicting interests of a series of specialized departments. These are run by other professionals who are in a position to challenge his authority.[98]

With both the professional and medical staff, then, the administrator must resort to the use of other techniques to gain compliance, rather than relying on compliance deriving solely from the legitimacy of his delegated administrative authority. As Moss states:

> ...as a result, he has a respect for the need to maintain a felititious balance of power among the majority of representatives of the principal power groups; the board, the medical staff and the administration. His strategies for information flow, the use of influence and persuasion, direct and indirect lobbying, and timing are derivatives of the political character of his situation as he understands it.[99]

This observation has a number of implications for the way the organization is managed, and the way in which coordination and integration are achieved.

In the earlier discussion, the hospital was described as an enucleated organization composed of two internally coupled structures. One structure, the paramedical-administrative sector, is highly differentiated both vertically and horizontally, and is in the service of the medical staff structure. While the board and the administrator are held responsible for the quality of care and services provided within the institution, neither are able to specify the procedures that are used by either the professional service staff, nor the medical staff. Furthermore, they are not able to directly assess the quality of care provided. Instead they must rely on both groups to perform these functions for them. While the administrator receives reports on the quality of services and care provided from the same colleagial organization that provides these services, his ability to assess and control that care is indirect. Indirect control is exercised partly through the board's control of the granting of hospital privileges to physicians, of course, on the recommendation of the medical staff, and through the board's and administrator's responsibility to ensure a functioning medical staff organization.

It is this medical staff organization, through its committee structure and chiefs of staff, that sets procedures, assesses and controls the quality of care provided, and recommends appointments to the medical staff. Despite the administrator's responsibility for ensuring the proper functioning of this medical staff organization, and the completion of medical records, he is likely to run into considerable resistance if he attempts to exercise that responsibility. Wilensky describes the administrator's dilemma succinctly when he states that:

> If the hospital administrator decides to intervene in such touchy matters as the use and payment of salaried medical specialists, the control of the quality of surgery, a death from a new drug or anaesthetic, or sometimes even on more routine matters of scheduling of operations and admission, or the use of proper techniques of sterilization, he is likely to be lectured about interfering with the "sacred doctor-patient relationship."[100]

In the hospital's management triangle,[101] the interaction between the board and administrator, and the board and the medical staff, is generally oriented towards long-term policy. On the other hand, the interaction between the administrator and the medical staff is oriented towards the "immediate" problems of integrating and coordinating the diverse activities that are carried on within and among the functionally differentiated departments of the hospitals. In part, the administrator can program coordination, since as has already been indicated, the medical technology available permits the rationalization of such activities. This permits the development of formalized procedures and operating rules and the functioning of other bureaucratic procedures, through the delegation of authority to department heads and formal lines of authority and control within departments.

While some of these areas may be rationalized and subject to rules, thereby removing them from continuous conflict in the "immediate" interaction between staff and administrator, other areas are less likely to be subject to rationalization. It is these areas where negotiatory behavior is most likely to be pronounced, or where external forces create pressure to alter the administrator's role so that he obtains more direct influence in areas where previously he and the board had indirect control. Furthermore, since the administrator is not able at times to utilize his administrative authority directly to solve some problems, he must use what D'Amours calls non-programmed forms of coordination. "Leadership, voluntary adjustments, shared frames of reference," and persuasion and consultation are the chief tools left to an actor whose counter-role partners do not always acknowledge his legitimate right to control their activities directly.[102] In these instances, and in functional areas when the administrator's authority is made contingent, he must resort to negotiatory behavior to achieve these ends.

Negotiation and the Administrator's Role

As James and Pierce point out, the administrator may have a limited or extended range of activities in which he is involved.[103] That is, he may withdraw to "safe," purely administrative-budgetary concerns, or become involved in community programs and medical staff organization. The extensiveness of the administrator's role, and his success in multiple and sometimes overlapping "arenas," depends a great deal on his "assessed stature." As Bucher points out, the wider the role-set and the higher the assessed stature, the greater the power and success in negotiating agreements. This relationship is clearly illustrated in the diagram below.[104]

The Relationship Between Extensiveness of Role-set, Assessed Stature and Power

	Assessed Stature	
Role-set	High	Low
Wide	Much and extensive power	Little or no power
Narrow	Narrow but effective power	Little or no power

Of course, the administrator's role-set may vary in the degree of consensus about the roles and arenas in which the administrator is expected to be involved.[105] Friedson's study of clinic physicians suggests that the assessed stature of a man is slow to develop. Bucher indicates as well that the criteria are often ambiguous and changing. Assessed stature develops slowly because, as Friedson notes:

> This collective definition ...is formed only among groups of physicians who have the opportunity to discuss such matters, and as a result there may be different pockets of opinion about the same clinic.[106]

The administrator who participates in multiple arenas, rather than confining himself to relatively narrow "administrative areas" (James and Pierce suggest the term "abdication"), increases his ability to negotiate successfully because he controls information. As Hanson points out, the administrator functions as a systemic linkage between the hospital and the community, the board and the medical staff, and among professional departments and the medical staff.[107] His functioning within different arenas, and the extent of overlap of persons among these arenas, affects the speed by which his assessed stature develops. The wider his role-set and the more interactionally disconnected the role-set and arenas, the slower the administrator's assessed stature will develop, and the greater the liklihood that a low consensus regarding the administrator's role definition will occur.

The administrator's ability to control information, and his general knowledge of organizational processes, also increase his ability to successfully negotiate at an interpersonal or coalitional level within different arenas, depending upon the individual or collectivities with whom he is involved. Brinkerhoff has shown that hierarchical status in an organization and utilization of conferences or committees are positively related.[108] The "functional alternative" - that is, "spontaneous consultation" - tends to reduce the use of conferences more for first line supervisors and middle level managers than for executives. Furthermore, the propensity to use staff conferences is greatest for middle-level and top executives. These observations would suggest that administrators tend to use both interpersonal and coalition negotiation arenas, while heads of departments would tend to rely primarily on informal, interpersonal arenas. Thompson points out that:

> The more complicated organizations... exhibit more organizational politics than the less complicated ones, for complexity means more or deeper interdependencies and therefore more points of contingency.[109]

He cites the hospital and the university as examples of highly political organizations. As shown in the earlier discussion, the hospital is composed of multiple structures, and while these structures function on some modified bureaucratic principles (for the reasons discussed above) the multiplicity and diversity of occupational and professional groups, and the high degree of functional differentiation ensures multiple, different, and often conflicting viewpoints and needs for resources. The probability that coalition behavior will occur is very high. As Bucher points out, coalitions form around different issues, and since issues affect different members of the organization differently, as new issues arise different coalitions develop. Of course, as Bucher notes, some issues are perpetual and reflect the split not only in "professional identities," but also in interests. While the administrator's loyalty lies with the board within the functioning of the management "triumvirate" the administrator may coalesce with the medical staff - of course for the return of their support on some other issue.[110]

It is at the interface between departments and professional groups that the greatest problems for the administrator are posed, because it is here that overall coordination of the hospital is achieved. At the managerial level are the various committee structures within the hospital, the arenas or those "...repetitive focal situations in which the life of the institution proceed."[111] Any chart of a hospital organization indicates the committees on which the administrator is either an ex officio or voting member. Liswood and Freedman have pointed out the importance of the "Management Coordinating Committee"[112] in achieving the important coordination and integration necessary among departments and the various functional sectors of the organization. The members of this committee include the administrator and the heads or directors of the various departments or sectors (e.g. nursing director, medical director, personnel director,). Committees such as these are important arenas for coalition negotiation because they are structures for organizational decision-making and policy-making. Bucher indicates that "Committees are the forum through which policy-making for the college as a whole occurs."[113] Such committees represent "... integration through a political process,"[114] because it is within such committees, at both the higher managerial and inter-departmental levels, that integrative and coordinative problems are handled, and where the different perspectives and problems of each sector are represented, and compromises on "alternative lines of action" are reached.

Such committees are becoming increasingly necessary for at least three reasons. One is that the size and complexity of the organization make it impossible for an administrator to be as aware of the problems that the technical sectors encounter as was the case when hospitals were smaller. Only the heads of those sectors are aware of these difficulties. However, their "awareness" is limited to their own sectors and this parochialism must be counteracted. Secondly, as already pointed out, the administrator is generally not trained to administer professional areas and activities directly and must provide some mechanisms by which those delegated officers who do administer these areas are made responsible and report to him. Thirdly, such committees may represent a functional means for removing the conflict in the dual or multiple authority system with which lower organizational participants have to cope.

In so far as these committees are arenas for decision-making, then, the description by Thompson and Tuden of four decision-making modalities is relevant. The first modality, "Decision by Computation," requires no choice, since causes and preferred outcomes are known and agreed upon. "Decision by Inspiration" refers to exactly the opposite condition. "Decision by Majority Judgement" occurs where causation is unknown or unclear, and therefore disputed, but preferred outcomes are known and shared. In this regard, they point out that "Lacking an acceptable 'proof' of the merits of alternatives, the organization must rely on judgement."[115] In these situations, specialists provide evidence from each of their areas, but none have complete and indisputable evidence, and there is differential perception and interpretation due to different identities and training. "Decision by Compromise" represents a similar situation, except that here there is agreement on causation but not on preferred outcomes. Both these latter decision-making modalities represent situations for negotiation among representatives of different groups.

Hospitals confront both types of situation with regard to both internal and external problems. Decisions must be made in coordinating committees regarding known disagreements between department heads, with many alternative solutions possible to such problems. Joint conference committees, while not making any formal decisions, must come to some agreement about policies that both the board and the medical staff might accept. Whatever negotiated agreements or decisions are arrived at within these committee structures, they depend for their implementation on the functioning of bureaucratic structures in the technical sectors.

The administrator's role within these committees is to represent administrative concerns and to ensure that such committees function properly. As Thompson points out, "...for the organization to be decisive and dynamic, the dispersed power must be reflected in and exercised through an inner circle." Thus, "In an organization with dispersed power, the central power figure is the individual who can manage the coalition."[116] Of course, the success of the administrator in playing this role depends on his "assessed stature" and the extensiveness of his role-set.

Since the administrator controls organizational resources, he is also likely to engage in interpersonal negotiations with individual members of the hospital community. Such negotiations can occur over the phone, in hallways and offices. Negotiated agreements between board chairmen and the administrator, for example, may occur over lunch, and support for organizational policy by medical staff may be insured through agreements reached with "respected" members of the medical staff who will support that policy.

Negotiation, as the term has been used, is a form of interaction and therefore involves at least two parties. That is, negotiation proceeds between a focal role actor and his counter role partner(s). Negotiation, as conceived here, is a process through which roles are created and/or adaptation and compromise among conflicting power groups is achieved. Negotiation is more likely to occur under certain organizational conditions than under other conditions. Negotiation by the administrator may be necessary due to the peculiar distribution of power among organizational actors at the managerial level, the types of decision-making situations that tend to occur at the executive level, and in a related manner, the confrontations that are likely to occur because of the professional diversity within the organization and the need to achieve integration and coordination.[116] The conditions for negotiation are favorable where there is no effective and developed technology or search techniques, but rather, only ideology and a reliance upon skills such as intuition-developed either through a long apprenticeship period or a particular sensitivity or empathy with particular problems. Finally, negotiation may become necessary because of certain structural characteristics of the role and the very nature of the role itself, that is, whether the role is institutionalized, evolving, or emergent. These conditions, beginning with the latter, will be discussed below.

Structural Characteristics of the Administrator's Role

As Everret Johnson has indicated, the administrator's role has been changing since the late nineteenth century. It would appear from Johnson's account that evolutionary periods have been followed by periods of equilibrium in the administrator's role. As the situations of hospitals changed, the equilibrium that had been achieved among the roles in the hospital were upset and a new period of role-change ensued. Johnson points out that:

> At this moment the position of the hospital administrator is entering another evolutionary phase. This is so despite the fact that the last two phases of development have occurred in the past ten years and not all hospitals are at the same stage of development. ...as a rule of thumb, it can be said that the larger the breadth of medical services of a hospital program, the more urbanized its service area, the more it is likely for the hospital administrator to be functioning at stage five.[118]

Cogswell posits a continuum of the degree of structuring of roles, and states that "...some roles are more fixed than others and may fall along a continuum from stably defined, to conflictually defined, to ill-defined."[119] Following Cogswell, then, it would be appropriate to describe the administrator's role in primarily an evolving - not an emergent - phase of role development.

Cogswell suggests that emerging roles have no historical past, whereas evolving roles may have shifted from either an emergent or an institutionalized stage of role development. For the role actor in either an emergent or evolving role, there will be few clearly defined and consensually validated norms (i.e. the rights and duties of the role are not institutionalized),[120] and the actor must attempt to develop a definition of his role through negotiative interaction with others.

The evolving nature of the role, then, is one condition affecting the negotiatory process. First, negotiation over role definitions is necessary because, while the position is institutionalized, the role is not fully defined. Second, because the role is evolving, - some conceptions of the administrator's role will exist. This represents the historical heritage of the role. However, because of internal and external forces, there are pressures for the administrator's role to expand into different functional areas. Negotiation will be necessary to change prior role conceptions, to reduce conflict among any role expectations that do exist, and to include expectations that will permit the incorporation of role performance in these new functional areas. These latter aspects of the role may be considered as emergent.

The structural situation of an emergent role (and therefore the role-reciprocal that is related to Ego's role) represents what Frank has organizationally defined as an "underdefined" organizational role, where "role expectations of administrative behavior are not well spelled out."[121] Institutionalized roles, following Frank, would be represented organizationally as "well-defined" roles, whereas evolving roles would be similar, organizationally, to Frank's second type of "over-defined" administrative roles. That is, Frank distinguishes between overdefined roles that are a result of excessive role definitions and those situations where "...conflicting expectations render a role, or indeed a set of roles, over-defined because, due to their very internal inconsistency, they cannot be satisfied."[122] In this latter situation, the role actor, i.e. the administrator, finds himself in an evolving over-defined role - in which the state of over-definition results from a complex, differentiated and sometimes unconnected set of role-senders whose definitions and expectations of the administrator conflict with one another. This would represent a situation of low role-consensus. This situation arises, as well, from the historical heritage of the role - that is, from prior role conceptions of the role.

Gross et.al.[123] found instances of low role consensus characterized by high intra-group consensus but low inter-group consensus. Such a situation, then, represents what Frank terms an over-defined role in his second sense. This situation is likely to arise where structural conditions are such that separate and relatively unconnected groups of role senders are engaged in interaction with the focal role in different arenas. For example, Bates and White found that groups whose authority was disputed tended to rate their own authority as high and gave the lowest rating to the group with whom they were in competition.[124] This situation arose most often between administrators and physicians, particularly in the area of the administration of patient care - such as in the establishment of hospital policies regarding the general treatment of patients. The next case in which there was disagreement regarding role definition was that between the board and the administrator. Everret Johnson recognizes this situation with regard to the evolving role of the administrator when he states that:

> There are two forces that will determine the speed with which the next evolutionary step is taken in the position of the hospital administrator: the trustees and the medical staff. Prior to this time, the medical staff has had relatively little to do with the enlargement of the hospital administrator's role. They may have complained about the growing authority of the position and the increasing bureaucracy of the organization, but because administrative growth has not been directed into the medical staff area, no major problems arose. Since the growth was a collecting of functions formerly performed by trustees, and adding new services, the medical staff was not affected. The next step will be significantly different because the need now is to increasingly integrate medical staff activities with hospital-staff activities and the inter-mingling of relationships cannot be ignored in this development. When that issue is faced the traditional question of the complete separation of administrator and medical staff activities must be answered.... Trustees expect greater leadership from the administrator than do the medical staff or hospital staff. This means that the trustees will encourage rapid expansion of administrator activities, because they believe he should be, or they actually do hold him, accountable for all hospital activities, including the administrative affairs of the medical staff. Trustees believe that the effective administrator is one who is concerned with all affairs of the hospital. Conversely, they believe an ineffective administrator is one who limits himself only to internal hospital staff activities.[125]

From this statement it is apparent that structural forces are such as to expand the administrator's role, but this expansion of the role will be resisted, particularly by the medical staff and the hospital staff. This would be reflected, of course, in the extent to which consensus exists among role-senders regarding the role conceptions of the administrator's role.

It is reasonable to expect that high consensus among the different groups will exist in "traditional areas" of hospital administration. Such areas include general administrative procedures, admission policies and budgeting, but not areas affecting patient care and assessment of medical care. It is in these latter areas where the role expansion of the administrator will be resisted, his authority questioned, and role negotiation most likely to occur. Thus, in those areas of action where the administrator's role has been "institutionalized," little conflict and negotiation is likely to occur. However, in those areas where the role is "evolving" and/or "emerging," considerable conflict and negotiatory behavior is likely to occur.

While both Ego's and Alter's behavior may be "normatively oriented," in the emergent and evolving role situation, behavior is not necessarily normatively prescribed. As Rushing[126] illustrates, behavior is oriented around the normative order when actors act "as if" a role existed. It is through interaction that a set of normative role prescriptions is developed. Negotiatory behavior and the use of various power strategies will be the mechanisms by which mutually acceptable role prescriptions are developed. The "Give and Take in Hospitals," represents the continuous flux and redefinition of rights, duties and powers that Burling and his associates discovered in their work in the early 1950's.[127]

The substance of the argument to this point is that the different functional areas of the administrator's role are in various stages of institutionalization. As has already been pointed out, certain traditional areas of the administrator's roles are institutionalized. Other aspects of the administrator's role are evolving and expanding into different functional areas. Accordingly, different degrees of role consensus are likely to exist among the administrator's counter role partners, regarding the role-conception of the administrator in different functional areas. From an organizational standpoint, then, some aspects of the administrator's role are under-defined, some over-defined, and some are well-defined. Whether or not there is a conscious effort by the system actors to develop role prescriptions, in their attempts to achieve certain desired goals or states, negotiation will ensue, and will result in the development of some role prescriptions. Such prescriptions, however, will be subject to negotiation as situations change. What is important to understand here is that certain characteristics of the roles at the managerial level, and the kinds of situations which surround such high organizational roles, ensure that negotiatory behavior will occur. All of this, however, rests upon the assumption that the normal bureaucratic mechanisms are operative in order to ensure that the negotiated agreements are carried out!

This is a rather crucial assumption, since, unlike Strauss and his associates, the investigator has not argued for one model of organization over the other. Rather, it has been argued that both conceptualizations - the bureaucratic and the negotiated order - are necessary to understand the operation of complex organizations. Also, as pointed out in the earlier discussion, it is inconceivable that an organization as complex and status oriented as the hospital, could function solely on the basis of "consultation." Furthermore, the differences in technologies and task structures ensure that some elements of bureaucracy will be present.

It is posited here, that the existence of bureaucratic elements facilitates the development of negotiated orders among some groups of the organization's members. This occurs because tasks that are largely routine, predictable, and which do not require high discretionary ability are easily rationalized and bureaucratized. On the other hand, negotiated orders tend to develop either where technologies are highly developed and intensive, or are poorly developed and only "ideologies" exist. In the former instance, negotiation and consultation ensure the coordination of complex roles, whereas in the latter case, negotiation occurs because roles are left undefined,[128] and diverse perspectives facilitate the development of an effective technology. In the former case, negotiation ensures the effective use of developed technologies; in the latter, it aids in the development of technology and role definitions. In both cases, the existence of bureaucracy and rationalized technologies in the lower segments of the organization ensures that negotiated agreements and decisions are carried out in a routine manner. If this did not occur, the negotiated order could not function properly, since without the assurance that the negotiated agreements would be carried out consistently over time, negotiative interaction would cease because of unfulfilled expectations of either or both of the actors.

Finally, negotiatory behavior is also more likely to occur where the power distribution tends to be equal. Negotiatory behavior, then, becomes an organizational mechanism through which compromise and compliance is achieved where "multiple leadership" is the characteristic organizational pattern as it is in the modern hospital. In this situation the administrator must:

> ...develop a negotiatory habit. (He) must not simply give orders, not just consult and listen, but learn how to negotiate - how to discern equities and rights, how to effect mutual exchanges to the end that settlements are worked out with a maximum of consensus by everyone involved.[129]

Of course, negotiation is not necessary where the administrator's authority is clearly not in question. It does become necessary, however, where powers are equal, and where authority and role definitions are unclear and unspecified. Such situations are most likely to occur where roles are emergent and alternative perspectives and preferences are possible. Structurally, these situations arise at the "interfaces" where the different functional groups of the hospital confront one another. Where differential conceptions of the focal role exist, negotiation and role creation are likely to occur together. This is most likely to occur for those aspects of the focal role which are evolving and/or emergent, and where there are different groups of role senders who are interactionally disconnected. Where the authority of the focal role is questioned, negotiation over rights and duties of the role-reciprocals is likely to occur. In these situations actors are likely to express dissatisfaction with the role relationship and to display various power strategies in attempting to define or have redefined the role reciprocal.

V. ANALYTIC ORIENTATION

The strategy used to analyze the organizational form of the acute care general hospital attempts to incorporate both an open-system and closed-system approach. The investigator argues, as Thompson does, that different levels and sectors of the organization are more sealed off from environmental influences than are other sectors. Specifically, many technical and administrative sectors of the organization (e.g. nursing care units, paramedical departments, maintenance, dietary,) are less subject to and affected by environmental influences, than are the managerial sectors which attempt to "buffer" and seal off the technical sectors.[130]

Further, organizations are conceived of as "...multigroup systems which are held together structurally by reciprocal role relations."[131] The multigroup systems vary in the type and degree of direct and indirect task dependencies that characterize the task and role relations among them. Because organizations, such as hospitals, are concerned with the "processing" of inputs (in this case patients - or disease entitities), "The technology or work-flow is the major criterion for designing the structure."[132] Organizations employ different forms of technology to achieve their goals, and the technologies vary both horizontally and vertically. The separate elements of the work flow form the basis of the multigroup systems, and the attempt to "homogenize" these units because of internal and external forces is based on technological, spatial, and temporal criteria. When combined, these differentiated, operating system, formed around the "primary task," are the basis for the horizontal and structural differentiation of an organization. Three major vertical levels of the organization - the technical, the managerial and the institutional - are distinguished and linked together by various control devices.

A guiding principle in the analysis of organizations states that changes in any one sector of the organization will have system wide consequences. A derivative of this would be that an analysis of one unit of the organization demands analysis of other organizational units.

The managerial level of the organization is a more "open" system than the socio-technical sectors. Thus, a closed system logic, utilizing a rationalized bureaucratic structure, would be expected to be employed by the managerial level in order to manage the socio-technical sectors of the organization. At the same time, however, due to the openness of the managerial level to environmental fluctuations, and the need to integrate a structurally complex organization, negotiated structures and behaviors will develop around the process of administrating and managing the organizational relationships.

VI. SUMMARY

In this chapter, two models of organizations have been discussed, namely the bureaucratic model and the negotiated o order, the role of the hospital administrator has been analyzed, and an analytic strategy for studying organizations has been presented.

The apparent deviancy of the general acute care hospital stems from the dual system of authority in the hospital - namely the administrative and the functional. While the problems in achieving coordination and integration are partly attributable to this dual system of authority, the analytic strategy used in this chapter suggested that the nature of the tasks and technologies employed by the hospital play a significant part in the creation of and solution to these problems. Specifically, the hospital is conceived of as both an open and closed system employing an intensive technology. The nature of the tasks, and the diverse array of techniques that are drawn upon in the provision of patient care, result in a highly differentiated organization - both vertically and horizontally. Furthermore, because some tasks are easily routinized while others require high discretion and training, the different horizontal and vertical sectors of the organization display different degrees of professionalism and bureaucracy. The following two propositions may be deduced from the above.

Proposition One[133]

> The higher the degree of professionalism, the lower the degree of bureaucratic authority, presence of rules, procedural specifications, and impersonality.

Proposition Two

> The higher the degree of professionalism, the higher the degree of bureaucratic division of labour and technical competence.

The hospital represents an enucleated bureaucracy that is composed of two internally coupled structures (i.e. the service-administrative component and the medical staff organization). Furthermore, the service-administrative component is highly differentiated, complex and decentralized. The staff organization in turn is highly differentiated and hierarchically arranged, but tends to function in a colleagial pattern and is, in turn, externally coupled to outside professional groups which specify procedures for the colleague group.

Negotiation is a form of interaction involving the exchange of rights and duties and the constant restructuring of role relationships that result in organizational "order." The concept of the negotiated order is particularly applicable where a technology is not specified, or where decision-making must occur requiring judgments and/or compromises. The latter situations occur where personnel have different training and ideologies and where problems are seen as having multiple causes and solutions. Since many different professionals, each of whom demand the right to be involved in decision-making, are brought into contact with each other in the hospital, the conditions for negotiation would appear to be favorable in those segments of the organization that are professionalized.

Proposition Three

> The greater the degree of professionalism, the greater the degree of negotiation.

Proposition Four

> Professionalism will be positively related to departmental committee decision-making.

Proposition Five

> Professionalism will be positively associated with intra-departmental decision-making.

Furthermore, professionals are likely to be involved in work tasks which involve uncertainty and require the use of discretion by the practioner. Such tasks and professional roles are, therefore, not likely to be specified and rationalized, and hence are likely to exibit role conflict and ambiguity.

Proposition Six

> The greater the degree of professionalism, the greater the role conflict and role ambiguity.

Since the hospital employs an intensive technology and cannot specify the structure of role relationships to guide inter-professional behavior, negotiatory behavior provides a mechanism by which coordination is achieved.

Proposition Seven

> The greater the role conflict and role ambiguity, the greater the degree of negotiation.

The negotiated order, however, does not necessarily replace bureaucracy, since the existence of bureaucratic elements in the organization assures that negotiated agreements will be put into effect. Furthermore, professional personnel are not likely to engage in negotiatory behavior with non-professionals, relying instead on rule-giving. Where an organizational unit is highly bureaucratic, negotiation is likely to be impeded because a rationalized, specified technology imposes a pre-defined structure of role relationships on the organizational members.

Proposition Eight

> The greater the bureaucracy, the lesser the degree of negotiation.

The hospital administrator's contemporary role involves the integration and coordination of hospital services. His is an evolving role, and while responsible to the board for the day-to-day operation of the hospital, he may find that his administrative superior-subordinate relationships with health professionals are not always validated by them. Similar difficulties are likely to arise with the medical staff, especially in functional areas that are not considered as "traditional" elements of the administrator's role. The administrator's ability to influence decisions depends on his assessed stature. In committees where decisions are made by compromise and judgment, the administrator is likely to engage in negotiatory behavior. Different members of the administrator's role-set are likely to have different conceptions of the administrator's role.

Proposition Nine

> Role consensus regarding the administrator's role is likely to be higher for traditional than non-traditional areas.

Proposition Ten

> Board members are more likely to agree that the administrator should be involved in non-traditional areas than are the medical staff.

FOOTNOTES

1. The distinction made between the bureaucratic and negotiated order is not meant to imply that these are two distinct "types" of organizations, such as is the case, for example, with Gouldner's "rational" and "natural" systems models, Burns and Stalker's Mechanistic-Organic types, or Etzioni's Compliance model. The distinction in this dissertation is based on a simplification of Strauss *et.al*'s discussion of conceptual models. The distinction at this point of the discussion is intended solely for purposes of convenience. The reader should be aware, however, that it is not entirely clear whether Strauss and his colleagues intend their strategy for analyzing organizations to be applicable to all organizations, or to apply solely to particular "types" of organizations, that is, professional organizations. See A. Strauss *et.al.*, *Psychiatric Ideologies and Institutions.* (New York: Free Press, 1964), Chapters 1 and 15; and A. Strauss *et.al.* *The Hospital in Modern Society*, ed. E. Friedson (New York: The Free Press, 1963), pp. 147-169.

2. M.R. Brinkerhoff and P.R. Kunz, *Complex Organizations and Their Environments* (Iowa: Brown Company, 1972), pp. XIV-XV. They make a distinction between formal and complex as this is applied to organizations.

3. Eugene Litwak, "Models of Bureaucracy which Permit Conflict," *American Journal of Sociology*, 67(September, 1961), pp. 177-184.

4. William R. Rosengren and Mark Lefton, *Hospitals and Patients* (New York: Atherton Press, 1969), pp. 50. This emphasis on the formal organization of general hospitals contrasts with the emphasis on the informal organization in mental hospitals, and partially accounts for the divergent findings between the two settings. It may also account for the moral indignation with the latter and the curiosity in the deviancy of the former.

5. C. Perrow, "Hospitals: Technology, Structure and Goals," *Handbook of Organizations*, ed. James G. March (Chicago: Rand McNally, 1965), pp. 910-970.

6. Harvey L. Smith, "Two Lines of Authority Are One Too Many," *Modern Hospital*, 84(March, 1955), pp. 48-52.

7. Rosengren and Lefton, *op.cit.*, pp. 137-144. Notice that this particular discussion focuses on ideological-technological distinctions, but prior to this their discussion is also concerned with administrative-technical relations. The distinction is similar to that implied by the dual authority structure, and has a number of implications regarding the future flexibility of general hospitals. Specifically, the flexibil-

flexibility and innovativeness which has characterized hospitals in the past in the technical and professional sectors may be partly responsible for present and future difficulties in general acute care hospitals having to re-orient themselves to regional planning, community planning and inter-agency coordination and cooperation. As Rosengren and Lefton point out, it is in the administrative sectors where there is less technology, and more ideology and "art," where the flexibility and innovativeness to cope with institutional problems will be found in the future. Indeed many of the authors on hospital administration argue that the administrator must be a "leader" in these areas - but the argument stems from a professionalization basis and not from the same basis that Rosengren and Lefton discuss. On the other hand, this is also the locus where the greatest economic pressures from external sources, especially from the government, are forcing administrators to engage in innovative programs such as inter-agency programs. How much such activity is due to the professionalization of hospital administrators, to ideological bases, to technological sophistication, or to economic and political pressures is an open question. See the following for a discussion of the above points: R.B. Ferguson, "The Effective Hospital Administrator Leads Board and Community Thinking," *Hospital Administration in Canada*, 8(January, 1966), pp. 29-32; R.B. Ferguson, "Today's Administrator Must Provide Leadership in Community Health," *Hospital Administration in Canada*, 10(March, 1968), p. 38, pp. 45-57; Bright Dornblazer, "The Hospital Administrator - His Emerging Role," *Hospital Administration*, 11(Fall, 1966), pp. 6-16; Douglas R. Brown, "A New Administrative Model for Hospitals," *Hospital Administration*, 12(Winter, 1967), pp. 6-24; and Mervyn Susser, *Community Psychiatry* (New York: Random House, 1968), note especially Chapter 10 for a case study of the difficulty in achieving inter-agency coordination at the technical levels of the organization.

8. E. John Rizos, "The Nature of Authority in Hospital Administration," *Hospital Management*, 1(February, 1965), pp. 77-80. Rizos states that: "Functional Authority, as for example the authority of a doctor when he treats a patient in the hospital, is a phenomenon related to a body of knowledge," p. 78. In contrast, his definition of administrative authority states that:

> "By administrative authority is meant the necessary part of relationships within the hospital aimed at the establishment and maintenance of the necessary orders for the attainment of its objectives. The focus of attention is not on expert knowledge as in functional authority, but on the ability to direct the hospital - a specialized knowledge in itself," p. 79.

Cf. W.I. Taylor, "Exercise of Authority in the Hospital," *Canadian Hospital*, 45(August, 1968), pp. 49-53.

9. *Ibid.*, pp. 78-79. Cf. Rue Bucher, "Social Process and Power in a Medical School," *Power in Organizations*, ed. Mayer N. Zald (Tennessee: Vanderbilt University Press, 1970), pp. 3-49. Rue Bucher makes a comparable distinction in this study of a medical school, where she identifies various arenas in which the "life of the institution proceeds." Her discussion indicates that it is often within these arenas that different professionals perform their work, create different professional identities, and whose expertise is most applicable, i.e. situationally specific. The same might be said of the hospital where different professional and semi-professional groups perform their work and claim expertise in different, specific, functional areas. Notice, however, that the two concepts (centers of authority and arenas) are not identical, since "arenas" appears to be a broader term that refers not only to sources and locales of authority, but to various other institutional tasks, i.e., policy-making, where persons from diverse centers of authority may be drawn together.

10. John M. Dutton and Richard E. Walton, "Interdepartmental Conflict and Cooperation: Two Contrasting Studies," *Organizations: Structure and Behavior*, ed. Joseph A. Litterer (New York: John Wiley and Sons, 1969), pp. 407-422; and Donald W. Cordes, "Proliferation of Hospital Professions is New Challenge to Management," *Modern Hospital*, 102(June, 1964), pp. 96-98.

11. Ronald G. Corwin, "The Professional Employee: A Study of Conflict in Nursing Roles," *Social Interaction and Patient Care*, eds. James K. Skipper and R.C. Leonard (Philadelphia: J.B. Lippincott, 1965), pp. 341-355.

12. It is not implied here that other goals do not exist in the hospital. Other goals such as institutional survival, research and education are very much in evidence. The point here is that the "work-flow" of the organization, and the major decisions and budgetary allocations, are directed towards patient care, making this a primary goal for most hospitals. This does not imply either, that there are no other goals beyond these primary and secondary goals at the organizational level. Many departments may have various sub-goals of their own, which may or may not be complementary to that of patient care. Nevertheless, the "work-flow" throughout the hospital reflects the primary orientation towards patient care, and these sub-goals are often justified and exist because of this primary organizational objective. C. Perrow, "The Analysis of Goals in Complex Organizations," *American Sociological Review*, 26(1961), pp. 854-866; and E. Chapple and L.R. Sayles, "Work Flow as the Basis for Organizational Design," *Organizations: Structure and Behavior*, ed. J. Litterer (New York: John Wiley and Sons, 1969), pp. 303-318.

13. S.W. Becker and G. Gordon, "An Entrepreneurial Theory of Formal Organization Part I: Patterns of Formal Organizations," *Administrative Science Quarterly*, 11(1966-67), pp.

315-344. These Theorists define an "Internally-coupled Bureaucracy" as a "...formal organization which contains two or more authority patterns in service to the other," and "functional decentralization" as the "Organization of autonomous units around sets of different subgoals.... All the divisions specify their own sets of complex procedures and they do so simultaneously," p. 316.

14. Mary E.W. Goss, "Administration and the Physician," Journal of Public Health, 52(1962), pp. 183-191. Cf. Mary E.W. Goss, "Patterns of Bureaucracy Among Hospital Staff Physicians," The Hospital in Modern Society (New York: The Free Press, 1963), pp. 170-194.

15. W.I. Taylor, "Exercise of Authority in the Hospital," op.cit. passim. The article contains an excellent discussion of this particular subject. Since the board of trustees is held responsible by the government for hospital by-laws, of which the medical staff by-laws are a part, the board is thereby responsible for the quality of care provided and for the physicians who practise in the organization. The administrator, as the delegated representative of the board for the day-to-day operation of the hospital, also becomes responsible for an effective medical staff organization. Cf. C.W. Eisele ed., The Medical Staff in the Modern Hospital (New York: McGraw-Hill, 1967); John F. Horty, "When is Administration Found Negligent," Modern Hospital, 102(February, 1964), pp. 68-70; and John F. Horty, "If Transfused Blood Causes Disease," Modern Hospital, 114(March, 1970), pp. 64-65. See also the discussion of the case of Darling vs. Charleston Community Memorial Hospital Care in Charles Letourneau (ed.), The Hospital Administrator (Chicago: Starling Publications, 1969), Chapter 20.

16. Alan D. Bauerschmidt, "The Hospital as a Prototype Organization," Hospital Administration (Spring, 1970), pp. 6-14.

17. Perrow, "Hospitals: Technology, Structure and Goals," op.cit. passim.

18. James D. Thompson, Organizations in Action (New York: McGraw-Hill, 1967); E. Friedson, "Review Essay: Health Factories, The New Industrial Sociology," Social Problems, 14 (Spring, 1967), pp. 493-500; Richard H. Hall, "Professionalization and Bureaucratization," American Sociological Review, 33(February, 1968), pp. 92-104; and Richard H. Hall, "Intraorganizational Structural Variation: Application of the Bureaucratic Model," Administrative Science Quarterly, 7(December, 1962), pp. 245-308.

19. H.O. Mauksch, "It Defies All Logic-But a Hospital Does Function," Social Interaction and Patient Care, eds. James K. Skipper and R.C. Leonard (Philadelphia: J.P. Lippincott, 1965), pp. 245-251. Cf. R.N. Wilson, "The Social Structure of a

General Hospital," op.cit., pp. 233-244.

20. The investigator does not wish to imply that difficulties are not present, but they are equally present in other organizations which presumably approach more closely Weber's Ideal Type. The investigator does wish to convey the relative effectiveness of hospitals in providing patient care. The dual authority system accounts for part of this effectiveness, as do the multiple centres of authority which are derived from the two bases of authority. However, recognition of the dual authority system raises some important questions about how the organization functions with such a system of controls. As Rosengren and Lefton point out:

> "Perhaps the single element which bears most directly upon the question of why hospitals seldom exactly resemble a bureaucracy is to be found in the often noted inconsistency in Weber's writings about bureaucracy. Weber tells us that authority in bureaucratic organizations resides in the hierarchy of offices and in demonstrated expertise. Yet the larger and more complex an organization, the more likely is it that expertise will be held by persons outside the administrative line. In hospitals, for example, most administrators are not medical experts, and most medical experts are not administrators. One line of authority deals with organization for work, and another deals with the conduct of work.... There is also a question to be raised about the differential requirements for centralized decision-making of different kinds of decisions and where decentralization occurs, the degree and means of formal coordination."

Rosengren and Lefton, Hospitals and Patients, op.cit., pp. 51-52. Cf. James D. Thompson and Frederick L. Bates, "Technology, Organization and Administration," Approaches to Organizational Design, ed. James D. Thompson (Pittsburgh: The University of Pittsburgh Press, 1966), pp. 165-180.

21. While the discussion in this section of the chapter is based largely on technology, the chapters on data analysis are not so organized. In those chapters the investigator is primarily interested in describing the variations and relationships among the more proximal variables such as professionalism, bureaucracy, negotiation. It is hoped that the discussion in this chapter will communicate the broad perspective the investigator feels is necessary to understand organizational processes, and the important, but complex role that technology plays in organizational functioning. The purpose of the project is more modest, however, than this chapter may appear to imply. The data analysis, accordingly, is restricted to a more circumscribed area, which does not include technology as the primary independent variable.

22. C. Perrow, "A Framework for the Comparative Analysis

of Organizations," American Sociological Review (April, 1967), pp. 194-208. Cf. E.O.Chapple and L.R. Syles, "Work-flow as a Basis for Organization Design," Organizations: Structure and Behavior, ed. J.A. Litterer (New York: John Wiley and Sons, Inc., 1969), pp. 303-318; Thompson, Organizations in Action, op.cit. pp. 14-16; Joan Woodward, Industrial Organization: Theory and Practice (London: Oxford University Press, 1965); Alan D. Bauerschmidt, "The Hospital as a Prototype Organization," op.cit., pp. 8-9; James C. Taylor, "Some Effects of Technology in Organization Change," Human Relations, 24(1971), pp. 105-123; G.D. Hage and Michael Aiken, "Routine Technology, Social Structure and Organization Goals," Administrative Science Quarterly, 14(1969), pp. 366-376.

23. C. Perrow, "A Framework for the Comparative Analysis of Organizations," op.cit. p. 195.

24. Thompson, Organizations in Action, op.cit. pp. 17-18.

25. G. Hage and M. Aiken, "Routine Technology, Social Structure and Goals," op.cit. p. 371.

26. G.D. Bell, "Formality vs Flexibility," ed. G.D. Bell, Organizations and Human Behavior (New Jersey: Prentice-Hall, 1967), pp. 98-106.

27. Ibid. p. 101. Bell makes the distinction between uniform work tasks and predictability clearer when he states:

> "A worker might be confronted by many unique and unexpected situations while carrying out his job; however, he might meet these unique events by performing tasks in a very repetitive, routine or...uniform way."

28. G.D. Bell, "The Influence of Technological Components of Work upon Management Control," Organizations: Structure and Behavior, ed. J.A. Litterer (New York: John Wiley and Sons), pp. 441-445; and G.D. Bell, "Predictability of Work Demands," ibid., pp. 446-452. In this study he finds a positive relationship between high predictability and routine work situations with low discretion. Cf. W.A. Rushing, "Organizational Size, Rules and Surveillance," Organizations: Structure and Behavior, ed. J.A. Litterer (New York: John Wiley and Sons, Inc., 1969), pp. 432-440.

29. C. Perrow, "A Framework for the Comparative Analysis of Complex Organizations," op.cit., p. 198

> "Power affects outcomes because it involves choices regarding basic goals and strategies. Discretion relates to choices among means and judgements of the critical and interdependent nature of tasks. The consequences of decisions in the case of discretion have no direct influence on the goals and strategies. These decisions are formed within the framework of accepted goals and strategies."

30. Thompson, Organizations in Action, op[illegible]., p. 177.

31. M. Crozier, The Bureaucratic Phenomenon (Chicago: University of Chicago Press, 1968), Chapter 6.

32. Perrow, "The Analysis of Goals," op.cit., pp. 860-861. Cf. Perrow, "Goal and the Power Structure," op.cit., pp. 124-132.

33. G. Gordon and S. Becker, "Changes in Medical Practice Bring Shifts in the Pattern of Power," Modern Hospital, 102 (February, 1964), pp. 89-91.

34. G. Hage and M. Aiken, "Routine Technology, Social Structure and Organizational Goals," op.cit., pp. 370-371.

35. Rose Laub Coser, "Authority and Decision-making in a Hospital: A Comparative Analysis," American Sociological Review, 23(1958), pp. 56-63.

36. Rose Laub Coser, "Alienation and the Social Structure: Case Analysis of a Hospital," The Hospital in Modern Society, ed. E. Friedson (New York: Free Press, 1963), pp. 231-265.

37. W.R. Scott, "Reactions to Supervision in an Heteronomous Professional Organization," Administrative Science Quarterly, 10(June, 1965), pp. 65-82.

38. Rose Laub Coser, "Insulation from Observability and Types of Social Conformity," American Sociological Review, 26(1961), pp. 28-39. Cf. Robert Merton, Social Theory and Social Structure (New York: Free Press, 1968), Chapters 6 and 7.

39. Robert N. Wilson, "The Physicians Changing Hospital Role," Medical Care: Readings in the Sociology of Medical Institutions, ed. W.R. Scott and E.H. Volkart (New York: John Wiley and Sons, Inc., 1966), pp. 406-419.

40. W.L. Nellis, "Plan of Organization is the Key to Effective Administration," Hospitals, 43(September, 1967), pp. 70-72.

41. W.R. Rosengren, "Role Determinateness in Hospital Administration," op.cit. p. 50. Cf. A. Etzioni, Modern Organizations (Englewood: Prentice-Hall, 1964).

42. H.L. Smith, "Two Lines of Authority," op.cit., p. 60. Cf. M. Goss, "Patterns of Bureaucracy Among Hospital Staff Physicians," The Hospital in Modern Society, ed. Eliott Friedson (New York: The Free Press, 1963), pp. 170-194. Goss points out in her review of hospital literature that:

> "These investigations indicate that, while physicians

are not generally employed by the hospital, they are functionally necessary for the hospital's continued operation; though they are ordinarily "production" workers rather than administrators, by virtue of their profession they enjoy higher prestige than those in other occupations who may officially operate the hospital; and even though the physicians hold staff positions that are nominally outside the line of authority in the hospital, their qualifications as medical experts enable them to exert influence and authority with regard to the behavior of all levels of hospital personnel. They are, in other words, in a strategic position to enforce their professional demands; and it would seem that the burden of adjustment - or its alternative, unresolved tension - consequently falls heavily on their co-workers in the hospital; nurses, technicians, administrators, trustees, and other personnel," p. 173.

43. E. Gross, "When Occupations Meet: Professions in Trouble," Hospital Administration, 12(Summer, 1967), pp. 40-59.

44. Renee C. Fox, "Training for Uncertainty in the Preclinical Years," Patients, Physicians and Illness, ed. E.G. Jaco (New York: Free Press, 1958), pp. 344-348. Uncertainty surrounds the decision regarding the diagnoses of disease types, the appropriate treatment technologies, and the appropriate mix of therapeutic techniques. Once procedures are decided upon, a relatively low degree of uncertainty surrounds the execution of those therapeutic procedures. As Lasagna points out, however, there is still some uncertainty as to the outcome of these treatment technologies. Louis Lasagna, "The Prognosis of Death," The Dying Patient, eds. O. Brim, et.al. (New York: Russell Sage Foundation, 1970), pp. 67-82. Notice that the discussion has been restricted to disease types or curative procedures, and has not referred to care procedures or "the Art of Medicine." For a discussion of the differences between care and cure see: M.M. Johnson and H.W. Martin, "A Sociological Analysis of the Nurse Role," Social Interaction and Patient Care, eds. J.K. Skipper and R.C. Leonard (Philadelphia: J.B. Lippincott Company, 1965), pp. 29-39; and J.K. Skipper, "The Role of the Hospital Nurse: Is It Instrumental or Expressive?," ibid., pp. 40-50. As has been pointed out by many authors, (e.g. O. Brim, et.al. The Dying Patient, op. cit. passim.; and E. Kubler-Ross, On Death and Dying (London: Collier-MacMillan, 1969). This is an area (death) which physicians prefer to avoid, especially with regard to some disease entities (i.e., terminal cancer), preferring to work with the tools they know are more reliable - that is, the rationalized science of medicine that is represented in the curative techniques developed so far. Care procedures are more often left to the nurse. It is this "art" and the greater reliance on intuition that Perrow is perhaps referring to when he argues that there is no rationalized scientific therapy for mental disease. See: Perrow, "Hos-

pitals: Technology, Structure and Goals," op.cit., pp. 913-916; and John H. Marx, "A Multidimensional Conception of Ideologies in Professional Arenas: The Case of the Mental Health Field," Pacific Sociological Review, vol. 12, no. 2 (Fall, 1969), pp. 76-78, for an excellent discussion of the role of ideology where an effective technique for treatment does not exist. This is possibly one reason why Strauss and his colleagues found that a negotiatory model is more appropriate to the mental hospital and to universities. The structure of action is based upon various ideologies which are not subject to empirical test in the immediate future.

45. W.R. Rosengren and M. Lefton, Hospitals and Patients (New York: Atherton Press, 1969), p. 53.

46. S. Becker and G. Gordon, "An Entrepreneurial Theory of Formal Organizations: Part I: Patterns of Formal Organizations," Administrative Science Quarterly, 11(1966-67), pp. 315-344.

47. Goss, "Patterns of Bureaucracy," op.cit., pp. 176-177.

48. A.L. Stinchcombe, "Bureaucratic and Craft Administration of Production: A Comparative Study," Administrative Science Quarterly, 4(1959), pp. 168-187.

49. The duality in the bases of authority in the hospital can be seen to stem partly from the nature of the technology employed, although this is not entirely true since the legal definition and source of administrative authority must also be recognized. Furthermore, as will be argued later, the administrator is also confronted with unpredictable, uncertain, high discretionary, and low routine tasks, but his authority stems primarily from administrative rather than professional bases of authority, although there are considerable pressures for the latter to develop. Brown, "A New Administrative Model," op.cit., pp. 12-24.

50. Eugene Litwak, "Models of Bureaucracy Which Permit Conflict," American Journal of Sociology, 67(September, 1961), pp. 177-184.

51. R.H. Hall and C. Tittle, "A Note on Bureaucracy and its 'Correlates'," American Journal of Sociology, 72(November, 1966), pp. 267-272. Cf. R.H. Hall, "Intra-Organizational Structural Variation," op.cit., pp. 297-301.

52. R.H. Hall, "Some Organizational Considerations in the Professional Organizational Relationship," Administrative Science Quarterly (December, 1967), pp. 461-178; and R.H. Hall, "Professionalization and Bureaucratization," American Sociological Review, 33(February, 1968), pp. 92-104.

53. R.H. Hall, "Intra-Organizational Structural Variation,"

op.cit., p. 300.

54. Robert W. Habenstein and Edwin Christ, Professionalizer, Traditionalizer, and Utilizer (Columbia: University of Missouri Press, 1955). Cf. Ronald Corwin, "The Professional Employee: A Study in Conflict of Nursing Roles," Social Interaction and Patient Care, eds. J.K. Skipper and R.C. Leonard (Philadelphia: J.B. Lippincott Company, 1965), pp. 341-355.

55. Notice that the prediction regarding the vertical and horizontal differences in the degree of bureaucracy which each of the separate functional units exhibits is based on the nature of the technology employed. This emphasis on the type of tasks performed, and on the technology employed and its importance as a determinant of organizational structure is a major assumption of this discussion.

56. R.K. Merton, "Bureaucratic Structure and Personality," Social Theory and Social Structure, op.cit., pp. 249-260.

57. R.H. Hall, "Professionalization and Bureaucratization," American Sociological Review, 33(February, 1968), pp. 92-104; Gloria V. Engel, "The Effect of Bureaucracy on the Professional Autonomy of the Physician," Journal of Health and Social Behavior, 10(1969), pp. 30-41; G.V. Engel, "Professional Autonomy and Bureaucratic Organization," Administrative Science Quarterly, 15(March, 1970), pp. 12-21; George Rosen, "The Impact of the Hospital on the Physician, the Patient and the Community," Hospital Administration, 9(Fall, 1964), pp. 15-33. Rosen provides historical support for this argument and shows that, despite the ideological claims of medicine, it was because, and not in spite of, physicians' attachment to hospitals and the bureaucratic organization that the quality of medical care was raised. (See: B.R. Blishen, Doctors and Doctrines: The Ideology of Medical Care in Canada (Toronto: University of Toronto Press, 1969). The consequent subjection of physicians to rules and regulations - and the possibility of the enforcement of those rules through increasing the observability and surveillance of their behavior by professional colleagues - had a significant positive impact on the practice of medicine. The scrutiny of other occupational groups has also played an important role in increasing the quality of care provided. (See: E. Gross, "When Occupations Meet...," op.cit., pp. 45-53). Control over members of the profession becomes possible only when surveillance and observability become possible. See: E. Friedson, The Profession of Medicine (New York: Dodd, Mead and Company, 1972), Part I.

58. R.H. Hall, "Professionalization and Bureaucratization," op.cit., p. 104. Hall states that:

> "...the implication is that in some cases an equilibrium may exist between the levels of professionalization and

bureaucratization in the sense that a particular level of professionalization may require a certain level of bureaucratization to maintain control. Too little bureaucratization may lead to many undefined operational areas if the profession itself has not developed operational standards for these areas. By the same token, conflict may ensue if the equilibrium is upset." (emphasis added)

59. Bell, "Influence of Technological Components," op.cit., pp. 444-445; and Bell, "Formality vs Flexibility," op.cit., pp. 103-104.

60. Jules Henry, "Formal Social Structure of a Psychiatric Hospital," Sociological Studies of Health and Sickness, ed. D. Apple (New York: McGraw-Hill, 1960), pp. 260-279. See also: Thompson, Organizations in Action, op.cit., pp. 88-93 for a good discussion of the organizations attempt to achieve rationality and assess performance, and the effect assessment procedures can have when organizational criteria are inappropriate.

61. W.R. Rosengren, "Role Determinateness in Hospital Administration," Hospital Administration, 5(Summer, 1960), pp. 46-57. Determinant Roles may be a result of organizational definition (see: G. Frank, "Administrative Role Definition and Social Change," Human Organization, 22(1963-64), pp. 238-242), or by a technology that specifies techniques.

62. Thompson and Bates, "Technology, Organization and Administration," op.cit., p. 170.

63. M.W. Meyer, "The Two Authority Structures of Bureaucratic Organization," Administrative Science Quarterly, (1968), pp. 211-228. Notice that this hierarchical differentiation varies by the size (number of employees) of the organization. See: P.M. Blau, "A Formal Theory of Differentiation in Organizations," American Sociological Review, 35(April, 1970), pp. 201-218. Meyer also argues that both patterns do not occur at the same time - but his conclusions may be limited by the type of organizations which he studied, that is, government agencies for financial administration.

64. G. Hage and M. Aiken, "Relationship of Centralization to Other Structural Properties," Administrative Science Quarterly, 12(1967-68), pp. 72-92. See also: G. Hage and M. Aiken, "Routine Technology, Social Structure and Organizational Goals," Administrative Science Quarterly, 14(1969), pp. 366-376; G. Hage, M. Aiken and C.B. Marret, "Organization Structure and Communication," American Sociological Review, 36 (October, 1971), pp. 860-871.

65. Bell, "Predictability of Work Demands," op.cit., pp. 451-452. On page 449 Bell provides a Job Description list of various hospital occupations. It is apparent from this table,

that in occupations such as housekeeping and laundry the degree of discretion and self-direction is low, whereas occupations such as physician, and hospital administrator are high discretionary and self-directive occupations.

66. Meilecke, "Parsonian Theory and the Modern Hospital," unpublished manuscript, 1963. pp. 18-19.

67. Bauerschmidt, "The Hospital as a Prototype Organization," op.cit., p. 10.

68 Albert F. Wessen, "Hospital Ideology and Communication Between Ward Personnel," Patients, Physicians and Illness, ed. G.E. Jaco (New York: Free Press, 1958), pp. 448-467.

69. James C. Taylor, "Some Effects of Technology in Organizational Change," Human Relations, 24(April, 1971), pp. 105-123.

70. J.D. Thompson and A. Tuden, "Strategies, Structures and Processes of Organizational Decisions," Approaches to Organizational Design, ed. J.D. Thompson (Pittsburgh: University of Pittsburgh Press, 1966), pp. 195-216.

71. A. Strauss, et.al., Psychiatric Ideologies and Institutions (New York: Free Press, 1964). Their reasons for developing a new model are not based solely on their dissatisfaction with existing models of Bureaucracy, but also on their desire to:

> "...focus upon the organization as an arena in which ideologies are put into operation, clarified, modified and transformed. We also wanted to focus on the ideology bearers themselves, that is, upon the psychiatrists and para-psychiatric specialists engaged in the care of patients, who do not always see eye-to-eye upon important matters. We needed a model that would permit us to focus upon cooperative and conflicting actions; rational and nonrational actions; structure and emergent behavior; ruled and nonruled behavior; formal and informal or spontaneous division of labor; overall institutional and subunit actions; intra-individual action and its relation to organizational action; total and partial institutional commitment; intra-organizational and extra-organizational pressures; 'social organization' and 'social process'." p. 14. Later they state:
>
> "Such findings suggest that organization theory, elaborated largely from studies of both bureaucracy and rather formalized industrial or governmental organizations, needs considerable modification to be meaningful for hospitals. When professionals are brought together and enjoined to carry out their work in the same locale, concepts of structure (formal and informal) as relatively set systems of

> norms and expectations are inadequate to explain resulting activity. The activity of interacting professionals is, we submit, largely governed by continual reconstitution of bases of work through negotiation," p. 375 (emphasis in original).

Compare the work of W.R. Rushing, The Psychiatric Professions (Chapel Hill: University of North Carolina Press, 1964) who also utilizes a model that approaches the conceptualization of Strauss, but not because the bureaucratic model is believed to be inappropriate, but because the organizational mileau does not provide role definitions in psychiatric hospitals. Thus in an institutionalizing phase, the roles are evolving or emergent. See: Gunder Frank, "Administrative Role Definition," op.cit. passim.

It should be pointed out that the lack of an appropriate technology in the treatment of mental illness would ensure the lack of role definitions (other than purely maintenance and housekeeping functions ...the technology of custodialism), and therefore ensure negotiatory behavior. (See: Perrow, "Hospitals: Technology, Structure and Goals," op.cit., pp. 924-925).

72. Strauss et.al., Psychiatric Ideologies and Institutions, op.cit.

> "All this varied activity, which eventuates in rules and agreements, does not take place accidentally. The specific content of rules and agreements is determined by how certain categories of people will encounter and perceive certain classes of repetitive situations... We should expect, therefore, that given types of agreement and negotiation will exist, with different frequencies, among different categories of personnel within the organization. These expectations flow initially from those more general organizational agreements about who shall staff the hospital and what tasks they shall undertake." p. 15.

73. Strauss et.al., Psychiatric Ideologies and Institutions, op.cit., p. 15.

74. G. Nettler, Explanations (New York: McGraw-Hill Book Company, 1970), Chapter Two.

75. Rue Bucher, "Social Process and Power in a Medical School," Power in Organizations ed. M.N. Zald (Tennessee: University of Vanderbilt Press, 1970), p. 30.

76. Rue Bucher and Joan Stelling, "Characteristics of Professional Organizations," Journal of Health and Social Behavior, 10(March, 1969), pp. 3-15.

77. Bucher, "Social Process and Power," op.cit. p. 25. And yet, it should be pointed out that despite Bucher's claim, a common place observation in such academic settings in Universities is the academicians rejection and hostility towards the administrative authority vested in the administrative staff. (See: G.F. Wieland, "The Determinants of Clarity in Organization Goals," Human Relations, 22(April, 1969), pp. 161-172), and the academicians orientation towards functional authority based on expertise rather than delegated administrative authority. The conflict between faculty and administration is as much due to a "dual authority system" and different technologies and environments, as it is in the hospital.

78. Strauss et.al., Psychiatric Ideologies and Institutions, op.cit., p. 375-376.

79. Ralph H. Turner, "Role-Taking: Process Versus Conformity," Human Behavior and Social Processes: An Interactionist Approach, ed. A. Rose (Boston: Houghton-Mifflin Company, 1962), pp. 20-40. Cf. Ralph H. Turner, "Role-Taking, Role Standpoint and Reference Group Behavior," Role Theory: Concepts and Research, eds. Bruce J. Biddle and E.J. Thomas (New York: John Wiley and Sons, Inc., 1966), pp. 151-158.

Rue Bucher and A. Strauss, "Professions in Process," Medical Care: Readings in the Sociology of Medical Institutions, eds. W.R. Scott and E.H. Volkart (New York: John Wiley and Sons, 1966), pp. 180-193. Cf. H.L. Smith, "Contingencies of Professional Differentiation," Man, Work and Society, eds. S. Nosow and W.H. Form (New York: Basic Books, 1962), pp. 219-224; R.M. Cyert and J.G. March, "The Goal Formation Process," Readings in Organizational Theory, eds. Walter A. Hill and D. Egan (Boston: Allyn and Bacon, 1966), pp. 99-114.

80. Thomas P. Wilson, "Conceptions of Interaction and Forms of Sociological Explanations," American Sociological Review, 35(August, 1970), pp. 697-709.

Bucher, "Social Processes and Power," op.cit., p. 19.

> "An Issue here is defined as any problem which has been taken up by some interested parties and enters the area of public discourse among the faculty; it also implies fairly wide faculty involvement. Some issues are more or less perpetual; that is they are not resolved, except temporarily, and come up recurrently."

Cf. Bucher and Stelling, "Characteristics of Professional Organizations," op.cit., pp. 8-10.

81. W.A. Rushing, The Psychiatric Professions, op.cit., pp. 698-702.

Bucher, "Social Process and Power," op.cit., pp. 4-5. See Also: W.A. Nolan, M.D., "The Making of a Surgeon," Readers Digest, (November, 1970), pp. 195-236. Cf. S.J. Miller, "Exchange and Negotiated Learning in Graduate Medical Education," Sociological Quarterly, 17(Fall, 1966), pp. 469-479.

82. Strauss et.al., Psychiatric Ideologies and Institutions, op.cit., p. 16 and p. 375. It appears from their account that the content and structure of the informal organization is precisely what is subject to negotiation. Negotiation regarding policy and resource allocation is as much a part of the formal structure and the setting of formal goals as it is of the informal structure. (See: Perrow, "The Analysis of Goals in Complex Organizations," American Sociological Review, 26 (1961), pp. 854-866). What the concept of negotiation appears to add to the concepts of formal and informal structures, is a conceptualization that has promise of describing the process or development of such structures and how such structures function at a social psychological level. At the same time it provides a conceptual link between that level of theorizing and the structural or sociological level. In short, it has promise of providing what Bergmann calls "process laws." (See: Gustav Bergmann, Philosophy of Science (Madison: The University of Wisconsin Press, 1966)).

83. Bucher, "Social Processes and Power," op.cit., p. 9. Similar to our earlier analysis of the technical sector of the general acute hospital, Bucher is arguing that the administration and medical staff organization are internally coupled. It now becomes appropriate to ask...how are the two organizations coupled, and are there really two internally coupled organizations - or is there simply one organization with enough internal differentiation which creates the appearance that there are two organizations? These questions raise the old problem of defining the boundaries of social systems. They essentially ask how is it possible to distinguish the professional from the administrative organization when both influence the operation of the other? While there have been many attempts to resolve these problems, little success has been achieved and the drawing of arbitrary boundaries is still the most frequently used device to resolve the issue.

84. B.G. Glazer and A. Strauss, The Discovery of Grounded Theory (Chicago: Aldine Publishing Company, 1967), pp. 61-62.

85. M.W. Goss, "Patterns of Bureaucracy Among Hospital Staff Physicians," op.cit., pp. 182-186. Cf. E. Friedson, "Processes of Control in a Company of Equals," op.cit., pp. 119-122; C.E. Biddwell and R. Vreeland, "Authority and Control in Client-Serving Organization," Readings in Organization Theory: Open System Approaches, ed. John G. Maurer (New York: Random House, 1971), pp. 192-199.

86. E. Friedson, "Review Essay: Health Factories, The New Industrial Sociology," Social Problems, 14(Spring, 1967), pp. 495-500. See also: J. Marx, "A Multi-Dimension Conception of Ideologies in Professional Arenas: The Case of the Mental Health Field," Pacific Sociological Review, 12(Fall, 1969), pp. 75-86

87. W.A. Rushing, "Social Influence and the Social Psychological Functions of Deference: A Study of Psychiatric Nursing," Social Interaction and Patient Care, eds. J.K. Skipper and R.C. Leonard (Philadelphia: J.P. Lippincott and Company, 1965), pp. 355-375. Notice that Rushing's discussion suggests that negotiation is restricted by status differentials which are built into the bureaucracy. Of course, we must recognize that "Status does set the problems around which negotiation proceeds," but a primary emphasis on the problems status differentials create and which are then subject to negotiation, would overlook the fact that bureaucratic prescriptions exist independently of the negotiatory process and may, in fact, make negotiation necessary. Cf. J. Berger, Bernard P. Cohen and M. Zelditch, "Status Characteristics and Social Interaction," American Sociological Review, 37(June, 1972), pp. 241-255.

88. J. Marx, "A Multi-Dimensional Conception of Ideologies," op.cit., p. 77.

> "The significance of ideologies in a professional arena is inversely related to the extent to which the phenomena or situations that practitioners must deal with have been completely and definitely understood. When complete understanding of the subject matter is obtained, competing ideologies can be replaced by broad agreement as to the appropriate general approaches and the more specialized techniques for dealing with any problem requiring professional attention."

Notice that it may be believed that there is an effective technology, although in reality there may be little empirical support for such beliefs.

89. Frances M. Tappan, Toward Understanding Administrators in the Medical Environment (London: MacMillan Company, 1968), p. 41. Cf. James A. Hamilton, Decision-Making in Hospital Administration: A Casebook (Minneapolis, University of Minnesota, 1960), p. 3; Bell, "Predictability of Work Demands," op.cit., p. 449.

90. Edith Lentz, "Hospital Administration - One of a Species," Administrative Science Quarterly, 11(March, 1957), pp. 444-463. See also: Perrow, "The Analysis of Goals in a Complex Organization," op.cit., pp. 860-861; Perrow, "Goals and Power Structures," op.cit. passim.

Bright N. Dornblazer, "The Hospital Administrator - His Emerging Role," *Hospital Administration*, 11(Fall, 1966), pp. 6-16. Gordon and Becker, "Changes in Medical Practice Bring Shifts in the Patterns of Power," *op.cit.*, pp. 154-156. E. Johnson, "The Continuing Evolution of the Hospital Administrator," *Hospital Administration*, (Spring, 1966), pp. 47-59. Notice that most of these authors are referring to the evolution of an occupation - or more specifically, to the processes of segmentalization and institutional negotiation.

91. See the following: Douglas R. Brown, "A New Administrative Model for Hospitals," *Hospital Administration*, 12 (Winter, 1967), pp. 6-24; E.S. Rogers, M.D., "Delegation and Control in Government-Hospital Relationships," *Hospital Administration*, 8(Summer, 1963), pp. 18-29; F. LeRocker and S.K. Howard, "What Decisions Do Trustees Actually Make?," *Modern Hospital*, 94(April, 1964), pp. 83-87; S.M. Morris, "Hospital Trusteeship," *Hospitals*, 43(April, 1969), pp. 119-122.

92. Perrow, "Analysis of Goals in Complex Organizations," *op.cit.*, p. 860.

93. Robert C. Hanson, "Administrator Responsibility in Large and Small Hospitals in a Metropolitan Community," *Journal of Health and Human Behavior*, 2(1961), pp. 199-204; see also: Robert C. Hanson, "The Systemic Linkage Hypothesis and Role Consensus: Patterns in Hospital-Community Relations," *American Sociological Review*, 27(1962), pp. 304-313; Miriam T. Dolson, "Study Shows Administrators are Joiners," *Modern Hospital*, 107(November, 1966), pp. 112-117: 121.

94. G. Rosen, "The Impact of the Hospital on the Physician, The Patient and the Community," *Hospital Administration*, 9 (Fall, 1964), pp. 15-33. Cf. G. Bugbee, "The Physician in the Hospital Organization," New England Journal of Medicine, 261 (October, 1959), pp. 896-901.

95. Donald W. Cordes, "Radius of Administrative Responsibility," *Hospitals*, 38(June, 1964), pp. 44-48: 128.

96. Bright N. Dornblazer, "The Hospital Administrator-His Emerging Role," *op.cit.*, pp. 8-10. Cf. Douglas R. Brown, "A New Administrative Model for Hospitals," *op.cit.*, pp. 13-14; *Task Force Reports on the Cost of Health Services in Canada*, Volumes 1,2,3 (Ottawa: Queens Printer, 1970); A.L. Whiting, *The Inside-Outside Concept in Senior Hospital Administration*, Unpublished Thesis (Kingston: University of Toronto), 1969.

97. C.A. Meilecke, *Parsonian Theory and the Modern Hospital*, Unpublished paper, 1963.

98. J. Murphy, "Role Expansion or Role Extension: Some

Conceptual Differences," Nursing Forum, 9(1970), pp. 383-390. Cf. F.M. Tappan, Toward Understanding Administrators in the Medical Environment (London: MacMillan Company, 1968), p. 44.

99. D.W. Cordes, "Proliferation of Hospital Professions is New Challenge to Management," Modern Hospital, 102(June, 1964), p. 97. Cf. A.B. Moss et.al., Hospital Policy Decisions: Process and Action (New York: G.B. Putnam and Sons, 1966), p. 105

100. M.L. Wilensky, "The Dynamics of Professionalism: The Case of Hospital Administration," Hospital Administration, 7(Spring, 1962), pp. 6-24. See especially page 21. Cf. Moss et.al., op.cit., pp. 153-154.

101. G. D'Amours, "The Triangle of Hospital Management," Canadian Hospital, (May, 1966), pp. 48-51.

102. D'Amours, op.cit., p. 49.

103. John Y. James and A.E. Pierce, "Patterns of the Administrative Process," Hospital Administration, 8(Winter, 1963), pp. 6-25. They identify six types of administrative process and coordinative areas of the administrator's power and power relationships. They are: A. Professionalism... "All functions except medical staff deals with Chief of Medical staff; B. Teamism...Hospital operation only, Stresses cooperation; C. Politicalism...Areas limited by his (administrator's) choice. Prevents difficulties by informal contacts; D. Partisanism..."Non-medical" patterns only. Challenged by medical staff; E. In-groupism...limited to non-secular affairs by mutual agreement. Stresses dedicated service; F. De Facto-ism...Abdication in several areas. Challenged and bypassed by others. See: p. 21-23.

104. Bucher, "Social Processes and Power," op.cit., p. 38.

105. F.L. Bates and R.F. White, "Differential Perceptions of Authority in Hospitals," Journal of Health and Social Behavior, 2(1961), pp. 262-267.

106. E. Friedson and B. Rhea, "Processes of Control in a Company of Equals," Social Problems, 11(Fall, 1963), pp. 119-131.

107. Hanson, "The Systemic Linkage Hypothesis," op.cit., p. 305.

108. M. Brinkerhoff, "Selected Structural Factors Which Influence the Administrative Staff Conferences," Paper Presented at Pacific Sociological Meetings, Portland, Oregon, 1972.

109. Thompson, *Organizations in Action*, *op.cit.*, p. 129.

110. Donald C. Carner, *The Administrator and Medical Staff Relations* (Motivation Inc., 1967).

111. Bucher, "Social Processes and Power," *op.cit.*, p. 12.

112. S. Liswood and T.J. Freedman, "Management Coordination - A Means of Participatory Administration," *Canadian Hospital*, 47(August, 1970), pp. 62-64. Cf. J.H. Carter, "Guidelines for Effective Use of Human Resources," *Canadian Hospital*, 47(January, 1970), pp. 39-42; 46.

113. Bucher, "Social Processes and Power in a Medical School," *op.cit.*, p. 44. Cf. Liswood and Freedman, *op.cit.*, p. 63 who state that:

> "Coordination and problem solving occur to a great extent at this meeting, as often a member or members will bring to the group a problem with which he needs advice or assistance, common problems to be discussed, or new programs which are to be coordinated."

114. Bucher and Stelling, "Characteristics of Professional Organizations," *op.cit.*, pp. 11-13.

115. Thompson and Tuden, *op.cit.*, p. 199.

116. Strauss *et.al.*, "The Hospital and Its Negotiated Order," *op.cit.*, p. 168. This is a variation of one of Strauss' conditions for negotiation - except that we are arguing that positional perspectives and frames of reference will differ due to hierarchical and positional variation, as well as professional background. These factors ensure ideological diversity. As Friedson has indicated, where there is a specified technology, there can be no "ideological" disputes because the "facts" are empirical and not subject to multiple interpretations. Negotiative behavior will be minimal. In so far as the administrator is concerned, the "facts" are often subject to ideological dispute and interpretation.

117. Everret Johnson, "The Continuing Evolution of the Hospital Administrator," *Hospital Administration*, (Spring, 1966), pp. 47-59. Johnson outlines five stages of evolution. They are:

> "Stage 1 - Superintendent of Nurses and Trustees;
> Stage 2 - Superintendent of Nurses, Business Manager, and Trustees;
> Stage 3 - Hospital Superintendent - Trustees;
> Stage 4 - Administrator;
> Stage 5 - Executive Vice-President," p. 51.

118. Johnson, *op.cit.*, p. 51.

119. Betty E. Cogswell, "Socialization into the Family: An Essay on Some Structural Properties of Roles," *Sourcebook in Marriage and the Family*, ed. M.B. Sussman (Boston: Houghton Mifflin Company, 1963), pp. 366-375.

120. Alvin W. Gouldner, "The Norm of Reciprocity: A Preliminary Statement," *Role Theory: Concepts and Research*, eds. B.J. Biddle and E.J. Thomas, (New York: John Wiley and Sons, 1966), pp. 139-140. If Alter did have a consensual definition of Ego's role, then it would not be possible to describe Ego's role as emergent. Rather it would be a situation involving the socialization of Ego into Alter's conception of the role. In the case of an emergent role, norms must not only be created, and a consensus developed, but both Ego and Alter must be socialized into their own roles and about the others roles. Cogswell's study of the process of socialization into the paraplegics role in the family is a case in point. See: Betty E. Cogswell, "Rehabilitation of Paraplegics," *Sociological Inquiry* 37(1967), pp. 11-26; Betty E. Cogswell, "Self-Socialization: Readjustment of Paraplegics in the Community," *Journal of Rehabilitation*, (May-June, 1968), pp. 11-13; 35; Betty E. Cogswell, "Some Structural Properties Influencing Socialization," *Administrative Science Quarterly*, 13(1968), pp. 414-440. The argument that both Ego and Alter must socialize into their own and each others roles, stems from the reciprocity of normative expectations, and from the fact that a role, by virtue of its systemic qualities, cannot be defined without reference to its counter role. See: Walter Coutu: "Role-playing vs Role-taking: An Appeal for Clarification," *American Sociological Review*, 16(1951), pp. 180-196; and Ragnar Rommetviet, *Social Norms and Roles* (Minneapolis: University of Minnesota Press, 1954).

121. A.G. Frank, "Administrative Role Definition and Social Change," *Human Organization*, 22(1963-64), pp. 238-242. We do not imply a one-to-one relationship between the types of roles Cogswell identifies and those Frank discusses. Nevertheless, there does appear to be some overlap among the definitions. This suggests a two-dimensional scheme which would allow for different combinations of the role types that have been identified. This is essentially how we have conceptualized the distinctions made. That is, Frank's distinction fall along one axis, and Cogswell's along the other.

122. Frank, *op.cit.*, p. 240.

123. Neal Gross *et.al.*, *Exploration in Role Analysis: Studies of the School Superintendency Role* (New York: John Wiley and Sons, Inc., 1966).

124. Frederick L. Bates and Rodney F. White, "Differential Perceptions of Authority in Hospitals," *Journal of Health and Human Behavior*, 2(1961), pp. 262-267.

125. Johnson, op.cit., pp. 52-53; 56.

126. Rushing, The Psychiatric Professions, op.cit., pp. 12-15.

127. T. Burling, E. Lentz and R.N. Wilson, The Give and Take in Hospitals (New York: G.P. Putnam and Sons, 1956).

128. Marx, op.cit., pp. 76-77. Marx argues that there are at least three characteristics of professional fields:

> "...which are unusually likely to generate ideologies in response to the inadequacy of other sources for determining professional behavior. They are:
>
> 1. Fields that are relatively new or recent and have undergone rapid growth in size, scope, social demand, or significance. These conditions maximize social pressures for professional action while at the same time the practitioner is unfamiliar with, and uncertain about, the phenomena toward which action is demanded...
> 2. Fields in which the application of empirically validated knowledge to concrete social problems depends upon personal, subjective-intuitive, 'particularistic' attributes of the practioner. Where extra-scientific consideration inhere in the application of scientific knowledge to social affairs and where practioners must rely, to an important extent, on the idiosyncratic 'art' of professional practice, the stage is set for divergent interpretations and, hence competing ideologies.
> 3. Fields in which moral and ethical considerations surround both the subject matter and the ends of professional action." pp. 76-77.

129. B.M. Selekman, as quoted in Hickey op.cit., p. 25.

130. Thompson, Organizations in Action, op.cit., Chapter 2. While such sectors absorb immediate fluctuations, nursing care units must adapt over the long run to some of these environmental changes. The important point here, of course, is that higher administrative levels attempt to discern trends in the external environment, "level-out" these fluctuations, and set policy which will introduce "predictability and rationality" in those changes and long-term adaptations that the lower technical sectors must make.

131. Frederick L. Bates, "Institutions, Organizations, and Communities," Pacific Sociological Review, 3(1960), pp. 59-70.

132. E. Chapple and L.R. Sayles, "Work Flow as the Basis for Organizational Design," op.cit., pp. 303.

133. We follow Dubin's distinction here between propositions and hypotheses. Since propositions are truth statement about a model that cannot be directly tested, a chapter on theory

and review of the literature would appear to be the proper place to place propositions. Hypotheses on the other hand, state the relationship between empirical indicators, that are taken to be the "...operations employed by a researcher to secure measurements of values of a unit" stated in a proposition. Therefore, our hypotheses will be stated at the end of our chapter on methodology after we have discussed our empirical indicators and have indicated why our indicators should be taken as an operations of the units stated in our proposition. See Robert Dubin, Theory Building (New York: The Free Press, 1969).

CHAPTER III

METHODOLOGY

In this chapter, the research design and methodology used in the study are described. The chapter is divided into the following five major sections: the research design, the data collection instruments, the sample, data analysis, and hypotheses.

I. THE RESEARCH DESIGN

Three basic steps were followed in the development and execution of the study. The first step involved a review of the literature and an exploratory phase in which interviews were conducted in a hospital over a two month period. The information collected during the exploratory period helped to indicate the kinds of problems that could be expected in the data collection stages of the project. It also provided additional information about the nature of the problem selected for study. This information was instrumental in modifying the original research proposal.

The information gathered during this first step of the research project indicated that a comparative approach, among a small number of hospitals, would be most likely to maximize the utility of the data that was collected. For example, it became evident that a survey of administrators alone, without collecting data on the socio-technical sectors of the organization with which the administrator had to work, would not yield the kind of understanding of the administrator's role that the project was intended to achieve. This suggested that a case study approach would be most applicable. It was felt, however, that case study material was itself limited in what it could indicate in general about the administrator's role. Hence, the study combined both a survey research design and a case study approach.

The second step of the project involved the selection of a sample and the development and pretesting of questionnaire and interview forms. One interview form and three questionnaires were developed for the study. All the research instruments were pretested in a small surgical hospital. Modifications to the final forms were made before the last phase of the project was begun. During this period letters were written to the administrators of the hospitals that were selected for the study. The nature of the project was explained and an attempt was made to secure their acceptance and support.

The third step of the project involved the administration of the interview and questionnaire forms.

II. THE DATA COLLECTION INSTRUMENTS

This second section of the chapter is organized into four subsections. Each subsection describes one of the four date collection instruments used in the study. The first subsection describes the Hospital Organization questionnaire. It is further subdivided by concepts and the discussion relevant to operationalizing each concept.

Hospital Organization Study Questionnaire

This questionnaire, administered to hospital personnel and staff, was designed to elicit information about the organizational structure of each of the participating hospitals. The questionnaire is reproduced in Appendix B. The literature and the theoretical perspective adopted for this study suggested that differences between sectors and departments of an organization, as well as between hospitals, could be expected to occur. Accordingly, the questionnaire was designed and distributed in such a way as to provide information on selected intraorganizational and interorganizational structural differences and similarities that might exist at the sociotechnical level. The discussion below describes only those concepts and operational indicators relevant to this study.

Professionalism. Hall[1] and Wilensky[2] have both indicated that professionalism includes a number of attributes. Hall has further suggested that these attributes are of two basic types. That is, first,

> ...those characteristics which are part of the structure of the occupation, including such things as formal education and entrance requirements. The second aspect of the model is attitudinal, including the sense of calling of the person to the field and the extent to which he uses professional colleagues as his major work reference.[3]

The operational indicators of professionalism adopted for this project attempted to include both attitudinal and structural attributes. An index of professionalism was constructed from eight questions (see questions 18 to 28, card I).

One of the indicators of professionalism was the amount of formal education the respondent had, since as Greenwood points out, underlying professional skills there is a systematic body of theory requiring a long training period.[3] Another indicator of professionalism was whether the person was certified or licensed to practice. Furthermore, membership in a professional association and attendance at professional meetings were taken to be two other indicators of professionalism. As Friedson has indicated, certification by and attendance at meetings of a professional association provide the mechanisms by which colleague control is exercised.[5] A final structural indicator of professionalism was whether or not the person read the journals of the associations to which he belonged. As a number of observers have pointed out, the body of knowledge of a profession is constantly being refined and subjected to further tests, and one of the main sources for the professional to update his knowledge are the professional journals. Following Wilensky, this aspect was included in the index of professionalism.[6]

Both Hall and Wilensky have further argued that colleague control and a concern for autonomy are central attitudinal aspects of a professional body. Thus, the reference group that should count most to a professional in the judgment of his work should be other professionals. As Wilensky has indicated, a concern for the judgment of either the client or the administrator, rather than the judgment of colleagues, should indicate either a service or administrative orientation and not a professional orientation.

Finally, the respondents were asked to indicate the most important aspect of their job. Indicators of a professional orientation were a concern for having the necessary materials and space to complete tasks,[7] a concern for autonomy in making decisions based on the person's "professional" judgment,[8] and an orientation towards the job as a learning opportunity. Other orientations that could be held were an administrative orientation and a client orientation.

A score for professionalism was obtained by adding together the number of points the respondent had accumulated for each of the indices. One point was awarded the respondent if they had a university or graduate degree, or if they had completed a two or three year nursing program. Other training was included, but only if that training was of a professional nature, such as specialization in surgical nursing. Having a professional license also counted as one point, whereas membership and attendance at professional meetings counted for one, two, or three points depending on the number of professional associations to which the person belonged and how often they attended meetings. A maximum of two points were possible if the respondent regularly read the journals of his professional association.

Three points were awarded to persons who indicated that only other professionals should evaluate their work, while two points were awarded those persons whose evaluation orientation was primarily professional, but also included one administrative or client evaluation. One point was awarded if the respondent had primarily a client orientation, but included one professional judgment. This was done in the belief that a client orientation is closer to a professional orientation than is an administrative orientation. That is, many of the so-called helping professions direct their ideology towards a concern for their client. As Friedson has pointed out, as well, consulting professions are subject to the pressures of clients.[9] The scoring procedure adopted here attempted to recognize the nature of the role relationship between a helping occupation and its clients. Somewhat similar distinctions have been made by Corwin, and these supported the decision to retain the scoring method used here.[10]

A similar procedure was followed with the job importance orientation. That is, three points were awarded for three answers indicating a professional concern for professional aspects of the job, two points if job concerns were primarily professional but included one client or administrative concern, and one point for two client concerns and one professional concern.

The higher the score, the more professional the respondent was considered to be. A maximum of 16 points was possible. Respondents were then categorized into high (16-11), medium (10-6), or low (5-0) degrees of professionalism. The score that could be obtained by a respondent was partially controlled. That is, if a respondent did not belong to a professional association, he also could not obtain points for reading professional journals or for attending the meetings of the professional association.

The above method of scoring gave greater weight to the structural than to attitudinal elements of professionalism. This was done to meet Friedson's criticisms that professional attitudes do not assure the degree of technological autonomy of an occupation which the structural differences among occupations provide.[11] Nevertheless, an attempt was made to determine if there was any difference in correlations between professional attitudes and the organizational variables, as compared to a structural score for professionalism. The results suggested little difference between a structural and an attitudinal analysis. Therefore, the total score for professionalism was retained. This was done because of the theoretical support for the scale. Also, given the lack of difference, and the considerable complexity in reporting separate results for each element of professionalism, the total score for professionalism seemed most appropriate for purposes of the report. While Hall reported a reliability of .80 for his scale, no reliability coefficient was computed for the scale used in this study, nor was one reported for Wilensky's measure.

Bureaucracy. This element of organization was conceptualized as a continuous, multi-dimensional concept.[12] Thus, organizations were not seen as being either bureaucratic or non-bureaucratic. Rather, organizations were conceptualized as exhibiting different degrees of bureaucracy both inter-organizationally and intra-organizationally.

Hall's measure of bureaucracy was used to operationalize the concept.[13] It allows for inter-organizational variation, and for vertical and horizontal intra-organizational variation in the degree of bureaucracy.

The scale is composed of six separate conceptual dimensions of bureaucracy. They are: hierarchy of authority, division of labour, rules for incumbents, procedural specifications, impersonality and technical competency. Due to the length of the Hospital Organization Study questionnaire, only 32 of the original 62 Likert-type items were used. The 32 items were selected on the basis of the highest score when each of the original test items were intercorrelated. Thus, based on the data provided by Hall, only those items that most clearly were independent of other scale items were selected.[14]

A further modification to Hall's original scale was made with regard to the response categories. Hall's original categories were: "definitely true, partially true, undecided, partially false and definitely false." The response categories used in this study were "very well, fairly well, poorly, not at all, and undecided." Like Hall, however, each of the above response categories was assigned a value from one to five. The alteration in response categories was done to maintain consistency in instructions between sections of the questionnaire, to avoid confusing the respondents, and to facilitate scoring and coding operations.

Questionnaire items are reproduced in the Hospital Organization questionnaire in Appendix B, under the section entitled Card II, (questions 36-67). Questionnaire numbers are listed below in Table 1, with the distribution of items for each scale.

A score of one and two indicated a high degree of bureaucracy, while a score of three and four indicated a low degree of bureaucracy for each separate scale. A score of five indicated no answer. Scores were computed for each scale by adding the score for each scale item together and dividing the total by the number of items in the scale.

Hall has indicated that the reliability coefficient for each scale is as follows: Hierarchy of Authority (.90), Division of Labour (.80), Rules for Incumbents (.83), Procedural Specifications (.83), Impersonality (.81), Technical Competency (.80). These reliability coefficients are for the entire 62 items in Hall's original measure. In addition, Hall has compared organizations that have been regarded as bureaucratic and nonbureaucratic, and concluded that the scales do, in fact, differentiate between hotels, state administrative agencies, banks, stock brokerage firms, attorney firms, a state regulative agency, and the sales and marketing divisions of an oil company. The differences between the scale scores for these organizations were significant at the .05 level of confidence using the two tailed t test.

Negotiation. As conceived in this study, the concept of negotiation was considered to be multi-dimensional. Any

TABLE 1
DISTRIBUTION OF QUESTIONNAIRE ITEMS AND ITEM NUMBERS IN THE QUESTIONNAIRE FOR EACH SCALE

			Total Number of Items
a)	Division of Labour	37, 42, 52, 54, 63	five
b)	Rules for Incumbents	38, 47, 49, 55, 64	five
c)	Procedural Specification	39, 43, 56, 60, 65	five
d)	Impersonality	44, 53, 57, 61, 66	five
e)	Technical Competency	40, 45, 50, 58, 67	five
f)	Hierarchy of Authority	36, 41, 46, 48, 51, 59, 62	seven

operationalization of the concept should reflect as much as possible the give-and-take in hospitals, the exchange of rights and duties, and the "agreements" that organizational actors arrive at over and above official rules and regulations, as well as about them. Five separate dimensions were developed to reflect what appeared to be the major types of negotiatory behavior, as that concept was "descriptively" discussed in the work of Strauss.[15] These five dimensions were: agreements negotiation, rule negotiation, committee negotiation, task negotiation, and interdepartmental negotiation.

A large number of questionnaire items were first assembled and pretested to determine which items were least ambiguous and which did not appear to overlap with items from other dimensions.

The face validity of the questionnaire items and the separate dimensions of negotiation were not considered to be adequate grounds to accept the revised scale of negotiation. Accordingly, a further test was made to determine if the questionnaire items could distinguish between medical and surgical nursing wards. Following Freidson's[16] and Coser's[17] discussion, it was expected that negotiatory responses would be higher in the medical than the surgical wards. Analysis of the pre-test data tended to support this prediction. The differences between the surgical and medical wards were significant at the .05 level, indicating that more negotiation occurred in the medical than surgical wards of the pre-test hospitals. No reliability scores were computed for any of the negotiation scales.

Response categories, similar to those used for bureaucracy, were employed in the measurement of negotiation. The distribution of questionnaire items for each scale of negotiation is reported in Table 2. These questions are reproduced in Appendix B in the Hospital Organization questionnaire under the section entitled Card III (questions 36-61).

As with the bureaucracy measurement, a score of one and two indicated a high degree of negotiation, while a score of three and four indicated little or no negotiatory behavior for each scale. The score for each scale was obtained by a adding together each of the scores for scale items and dividing by the total number of items in the scale.

The agreements dimension of negotiation attempts to measure that form of negotiatory behavior that is "tacit" or implied by certain actions. The consequence of such behaviors are agreements among organizational actors which are not necessarily directed at determining rules or the division of labour and tasks. Agreements negotiation results in "everyday understandings."[18] That is, over and above the rules or the division of labour which direct behavior, organizational members must accommodate themselves to each others' idiosyncratic behavior, or to the demands of their work environment which have not yet been "rationalized."[19]

Task negotiation, on the other hand, is specifically focused on "who does what," and sometimes on how a task should be done to fit the demands of the work environment. Rule

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TABLE 2
DISTRIBUTION OF QUESTIONNAIRE ITEMS AND ITEM NUMBERS FOR EACH SCALE

Negotiation Scale	Questionnaire Number	Total Number of Items
a) Rule	37, 42, 44, 46, 53, 58, 60	seven
b) Task	43, 45, 49, 57, 59, 61	six
c) Agreements	36, 39, 40, 47, 50	five
d) Committee	38, 41, 48, 54	four
e) Interdepartmental	51, 52, 55, 56	four

negotiation is also conceived to be a specific form of negotiation applying to ruled behavior.[20] That is, rule negotiation applies to those situations where interactants attempt to establish rules where none previously existed, or where they attempt to change rules to fit the demands of an "unpredictable" circumstance that a pre-existing rule does not appear to fit. As Strauss points out:

> That reconstituting of the social order, we would hazard, can be fruitfully conceived in terms of a complex relationship between the daily negotiative process and a periodic appraisal process. The former not only allows the daily work to get done; it also reacts back upon the more formalized - and permanent - rules and policies. . . . in turn, of course, the policies and rules serve to set the limits of some of the directions of negotiation.[21]

Committee negotiation refers to those specific "arenas" where interactants meet in a formal setting in order to determine policy, rules, or to resolve issues and conflicts.[22] Interdepartmental negotiation is intended to measure the existence of negotiatory behavior that occurs at the interface between departments. While committee and interdepartmental negotiation are specific to type of setting, they are not independent in so far as they may each be focused on rule or task negotiation. The two former types of negotiation may include the two latter types in some instances.

Supervisory skills. Mann has indicated the importance of supervisory skills in both the general hospital[23] and the electric power company,[24] and suggested that three types of supervisory skills are necessary in a supervisor. The supervisory skill mix depends upon the level of the department in the organization, technological sophistication, and the demands on the position, including the type of employee. One type of supervisory skill mix is technical skill or competence, by which Mann "...refers to the ability to use pertinent knowledge, methods, techniques and equipment necessary for the performance of specific tasks and activities, and for the direction of such performance."[25] By human relations skills is meant the "...ability to use pertinent knowledge and methods for working with people and through people."[26] A third and final type of supervisory skill is administrative skill, or:

> ...the ability of the supervisor to think and act in terms of the total system within which he operates - in terms of the organization as a system of people, and physical objects, with its own image, structure, and process, which functions as a continuing complex problem-solving arrangement to attain particular objectives.[27]

To measure supervisory skills, 11 questions, adapted from Mann, were asked. The technical skill index and the administrative skill index each contained three questions, and the human-relations skill index contained five items (see Appendix B, Card I, questions 32-34, 44-51). Respondents were asked to rank their supervisors on a scale from 0% to 100%. For example, to the question, "How much does your immediate supervisor know about doing each of the jobs in your area?", a respondent could indicate 100%, 60%, 20%, and so on. Replies were coded as high (100-61%), medium (60-40%), and low (39-0%). A composite score for each supervisory index was obtained by adding together the answers to each of the individual items pertinent to each of the supervisory skills.

Mann and Georgopoulos have shown that each of the three skills are independent of each other. Each skill was identified through factor analysis.[28]

Job satisfaction. Georgopoulos and Mann's work in The Community General Hospital indicated that job satisfaction is affected by supervisory style, thereby indirectly affecting the quality of care provided. Other conditions that are likely to affect job satisfaction, hence the organizational climate and quality of care, are the degree of bureaucracy, the degree of role conflict and of role ambiguity which role encumbents experience.

Seven questions, involving a scale from completely satisfied (100%) to completely unsatisfied (0%), were developed to measure the job satisfaction of hospital respondents. The questions are reproduced in Appendix B, Card I, questions 37-42. A total job satisfaction score was also computed from the individual score on each of the seven items. A final score of high (0-16), medium (17-26), or low (27-35) was assigned each respondent on the basis of his computed total of the seven questions.

Role conflict and role ambiguity. Both Pondy[29] and Corwin[30] have reviewed some of the literature on organizational conflict. Both indicate that conflict, either as an independent or dependent variable, is important to consider in research on organizations. As a dependent variable, Corwin has indicated that the degree of structural differentiation, linkage and boundary problems between units, the number of levels of authority or degree of bureaucracy are all positively related to conflict. Rizzo, House and Lirtzman have indicated that:

> ...role ambiguity - lack of the necessary information available to a given organizational position - will result in coping behavior by the role incumbent, which may take the form of attempts to solve the problem to avoid the sources of stress, or to use defense mechanisms which distort the reality of the situation. Thus, according to role theory, ambiguity should increase the probability that a person will be dissatisfied with his role, will experience anxiety, will distort reality, and will thus perform less effectively.[31]

Multiple lines of authority, they argue, increase role conflict and dissatisfaction of organizational members, thereby creating a loss of organizational efficiency and effectiveness.[32]

Role conflict and role ambiguity were operationalized using 14 Likert-type questions from Rizzo, House and Lirtzman's research (see Appendix B, Card I, questions 57-70). From their list of 30 test items, eight were selected from the role conflict items and six from the role ambiguity items. These were items with the highest factor loading on each of the conceptual variables. They reported reliabilities of .82 and .80 respectively for their scales of role conflict and role ambiguity. Scores of high, medium or low for both role conflict and role ambiguity were assigned to each respondent. Score totals were obtained by adding together the questionnaire items relevant to each of the conceptual variables. Role conflict and role ambiguity items were interspersed and role ambiguity items reversed to reduce response set. Thus, the cutting points for role conflict were: high 0-16, medium 17-27, and low

28-40; while for role ambiguity they were: high 20-30, medium 11-19, and low 0-10. Finally, a composite score was calculated by adding together both of the scores for role conflict and role ambiguity.

Intra-departmental coordination. Coordination was measured by asking respondents to indicate, on a six point scale from 0% to 100%, how difficult it was to find out what happened on the shift prior to theirs, and also how often work, that should have been handled by others, was left over from a previous shift (see Appendix B, Card I, questions 35-36). Total coordination was determined by adding together the scores for each item, and categorizing the scores into low (0-13), medium (14-23), and high (24-30) coordination.

Committee and inter-personal decision-making. Decisions, in an organization, can be made through formal apparatus such as committees, or informally via the social networks that exist.

Both modes of decision-making were operationalized by asking the respondents to indicate in one question how often decisions were made in their departments in committees and in another question, how often through decision-making among themselves (see Appendix B, Card I, questions 30-31). Respondents rated their departments on a six point scale from 0% to 100%. Ratings were subsequently categorized into high (100-61%), medium (60-40%), and low (39-0%).

Intra-departmental relations. Intra-group relations affects the cohesiveness of a group and its productivity, as well as influencing the behavior of other groups in organizations. Fiedler refers to this aspect as group atmosphere.[33] Accordingly, the group atmosphere scale was used to measure intra-departmental group relations. The scale consists of 10 word pair opposites as in the semantic differential test and has been reported to have reliability of .90 (see Appendix B, Card I, question 56).[34] Respondents were asked to rate their departments on an eight point scale. A composite score was then computed by adding together the scores for each of the 10 words. A total of 80 was possible. These scores were then categorized into high (80-56), medium (55-32), and low (31-0).

Summary of Hospital Organization questionnaire. Table 3 briefly summarizes the measures and concepts used in the Hospital Organization questionnaire.

Since an intercorrelational analysis will be executed in Chapter V in an effort to explore the relationship among the organizational factors, Table 4 summarizes the status of the variables in this correlational analysis. Some variables are used as both a dependent variable and an independent variable.

It should be pointed out here that organizational position or job was also used as an independent variable to determine if it had any impact on the organizational variables. Since this analysis did not reveal any significant findings, organizational position was dropped from further consideration in this study. The reader should be aware, however, that

TABLE 3

SUMMARY TABLE OF CONCEPTS AND MEASURES

Bureaucracy	A measure consisting of six separate scales to measure six dimensions of bureaucracy (Hierarchy of Authority, Division of Labour, Rules for Encumbents, Procedural Specifications, Impersonality and Technical Competency).
Negotiation	A measure consisting of five separate scales to measure five types of negotiation (Agreements, Task, Rule, Committee, and Inter-department).
Professionalism	A composite score of structural and attitudinal aspects of professionalism.
Supervisory Skills	Three types of supervisory skills consisting of administrative, technical and human relations skills.
Job Satisfaction	A composite score of seven questions directed at seven aspects of satisfaction with the job.
Role Conflict and Ambiguity	Composite scores obtained from fourteen items indicating conflict in expectations or ambiguity about expectations of rules.
Coordination	Composite score from two items indicating extent to which departmental activities and tasks are organized.
Committee Decision-making	Score based on the extent to which department members participate in decision-making in formal meetings.
Inter-personal Decision-making	Score indicating extent to which department members participate in decision making in informal networks.
Intra-departmental Relations	Composite score measuring the type of relationships within the department.

TABLE 4
STATUS OF ORGANIZATIONAL VARIABLES

Status as Independent Variable	Status as Dependent Variable
Bureaucracy	Bureaucracy
Negotiation	Negotiation
Professionalism	Committee Decision-making
Role conflict	Inter-personal decision-making
Role Ambiguity	Role Conflict
Supervisory Skills	Role Ambiguity
	Job Satisfaction
	Supervisory Skills
	Coordination
	Intra-departmental Relations

this factor was taken into consideration.

Areas of Hospital Operation Form

An attempt was made to measure the perceived importance of different problem areas in the operation of the hospital. The measure is based upon the social psychological principle that actors in different positions are likely to perceive their environment differently, and that this "definition of the situation" in turn will influence their behavior.

Prior research by Charles Prall[35] in 1948 and continued by Dolson[36] in 1965, indicated that the importance of problem areas in the administration of hospitals, as rated by administrators, had changed in some areas from one time period to the next.

The problem area items used in this study were the same as those used by Dolson in her report on 200 administrators. Included in the Dolson items were questions regarding problems with department heads and departmental functioning, business and financial management, community relationships, education programs, external controls, governing boards, legal aspects, medical staff, personnel management, physical plant, research programs, and the planning of patient care services. There were 12 items in all. This questionnaire is reproduced in Appendix C.

The administrator and his assistants were asked to rank each of the items according to how critical each area was to them in the operation of the hospital. The ranks assigned each of the areas were compared among the administrators of each of the different hospitals. The results obtained in this study were also compared with those of the Prall and Dolson studies.

Roles Conception Questionnaire

A role consists of a set of expectations or norms involving rights and duties. Because roles are built upon the norm of reciprocity, they are the framework through which interaction proceeds, and the basic units upon which different social structures are built. The behavior of organizational actors, therefore, is mediated through the roles they occupy and the expectations that adhere to those roles. As Jackson[37] and Gross[38] have shown, however, consensus about a role's expectations among a role occupant's counter role partners is problematic and cannot be assumed. Furthermore, due to the reciprocal nature of roles, a role cannot be defined without understanding the reciprocal expectations of its counter roles.

Bates and White have shown that consensus varied among nurses, trustees, physicians and administrators about the extent to which their own role and those of the others involved participation in decision-making in different areas of hospital operation.[39] That is to say, organizational actors differed in their role conceptions regarding the expectations about their own roles and the expectations they had of other roles in the organization.

A Roles Conception questionnaire was developed to determine the expected degree of involvement which physicians, administrators and trustees should have in making decisions about different operational areas of the hospital. This questionnaire is reproduced in Appendix D.

Questionnaire items were developed around the problem areas discussed by Prall and Dolson. The questionnaire items were also developed in such a way as to be divided into traditional and non-traditional areas of involvement of the administrator.[40]

Questions were developed using case study material and information from texts on hospital administration.[41] Furthermore, areas that seemed to be most relevant as determined from the two month observation period were included. A content review of hospital administration journals was also conducted in order to extract ~~a~~ universe of items that could be used in the Roles Conception questionnaire. Items were selected if they appeared in case study material, were discussed as problems in hospital administration journals, and were perceived as problem areas by the administrator and his assistants in the observation period. Also included in a pretest instrument were problem areas that seemed either to be considered critical only in the journals or during the observation period. All these items were submitted to two judges, both of whom were hospital administrators, for their evaluation as being relevant to Canadian hospitals and their general importance. Some items were dropped after this initial judging (none were added as the judges felt the items were adequate) and a pretest conducted in the pretest hospital on the remaining items.

Administrators and their immediate organizational counter role members, such as the directors of nursing, assistant administrators, and business managers, were asked to complete the questionnaire. Members of the board of trustees and the medical staff also completed the Roles Conception questionnaire.

Respondents were asked to indicate the expected degree of power to make decisions that the board, the medical staff, and the administrator should have in each of the areas. Four possible degrees of involvement were provided. They were: "should have the power to decide," "should be able to make recommendations," "may or may not express an opinion," "absolutely should not be involved."

The Interviews

The interviews ranged from an hour to two hours in length. In most instances, interviews with the administrators lasted two hours, while the interviews with the assistant administrators, directors of nursing, business and office managers and others lasted one hour. All interviews were conducted in the hospitals and in most cases in the offices of the interviewees.

In most cases, the administrators were interviewed twice, since they were the focal role on which the study was centered, and it became apparent that the second session proved more fruitful. These second interviews were used to clarify points that arose from the first interview, as well as to complete some of the sections of the interviews that were not covered in the first.

The areas covered in the interviews included coordination and control methods, administrator relations with the medical staff, board of trustees and nursing staff, the use of committees, techniques for resolving inter-departmental conflict, the establishment of and changes in policies and procedures, maintenance and improvement of standards of patient care and, finally, functioning of the medical staff organization. The interview schedule is reproduced in Appendix E.

Broad, general questions were used to introduce each area, and were followed by more detailed questions and probes where necessary. The interview forms and questions were standardized, except of course, where the respondents were probed for more detailed information.

III. THE SAMPLE

Selection of Hospital Sample

The research problem focused on the hospital administrator and the manner in which he played his role within an organizational context. It was necessary, therefore, to first select the organizations that were to participate in the project, before the respondents could be selected. The size and selection of the project's hospital sample was directed by the research concerns. In turn, the type and number of organizations included in the project affected the size and characteristics of the respondent sample.

Only general acute hospitals were selected, thereby excluding special and chronic care hospitals from the analysis. Furthermore, only hospitals with 100 or more beds were included. While it would have been desirable to include all types and sizes of hospitals, it was impossible to do so because of time and cost limitations. Also, the characteristics of the smaller hospitals (100 beds or less), and of their hospital administrators, were divergent enough from the larger hospitals to make comparisons across samples difficult to draw. The research problem was not directed towards the type of differences that would have been encountered if small hospitals, special, and chronic care hospitals had been included. Furthermore, the administrator's tasks are more broad and complex in the larger hospital than in the smaller, where plant, personnel and budgetary matters are of primary concern.[42] In the larger hospital, integration and coordination problems are more immediate concerns of the administrator. Concomitant with organizational size is the diversity in technology, functions and personnel. This is, of course, why size is a significant variable. It is not the factor of size itself, but what is associated with it.[43] A final rationalization for limiting the analysis to hospitals of 100 beds or more was that the greatest expense for health care in general hospitals is incurred in hospitals of this size. Their costs and efficiency are, therefore, of great concern to external agencies.

The 1968 Canadian Hospital Directory was used to select five hospitals for study.[44] The distribution of the project hospitals is outlined in Table 5 according to bed size, type and staff size. Table 6 presents the total number of public general hospitals, by size, at the time the study was undertaken.

One large hospital (500 beds or more) was selected. Urban Hospital had a nursing school attached and an intern program as well. It was located in a city in which there were three other large hospitals. South Eastern Hospital, a medium sized hospital, was selected because of its intermediate size, and because it was the only hospital serving the community in which it was located. Midland was also a medium sized hospital and the only general acute facility in the town. It had a nursing school attached. Southern Municipal and Southern Religious were selected because they were of medium size, and were located in the same community. Both had nursing schools. Furthermore, one was municipal and the other religious. It was felt that the contrasts in size, community inter-dependence with other hospitals, and classification types represented in the sample would help reduce the limitations of the case study approach.

The discussion below outlines the procedures followed in selecting hospital respondents, once the hospitals themselves had been determined. The discussion also indicates

TABLE 5
PROJECT HOSPITALS BY SELECTED CHARACTERISTICS, 1968.

Hospital	Type	Bed Size	Number of Personnel	Budget	Average Stay
Urban	Public Municipal	924	1,198	$11,240,000	8.4 Days
Midland	Public Municipal	152	261	1,550,000	6.85
Southern Municipal	Public Municipal	193	477	2,081,022	10.2
Southern Religious	Roman Catholic	207	443	2,017,000	9.3
South Eastern	Municipal Public	231	456	2,008,800	9.04

Adapted from: Canadian Hospital Directory, 1968.

TABLE 6
PUBLIC GENERAL HOSPITAL BY BED
SIZE GROUPS FOR ALBERTA, 1968.

Type	1-9	10-24	25-49	50-99	100-199	200-299	300-499	500+	Total
Lay	1	1	2		1		3	1	9
Religious		4	15	10	2	1			32
Municipal		19	32	18	4	1		2	76
Provincial								1	1
Total	1	24	49	28	7	2	3	4	118

Adapted from: Canadian Hospital Directory, 1968.

which of the instruments the respondents received.

Selection of Hospital Respondents and Instruments Used with Different Respondent Groups.

Hospital Organization questionnaire. In all hospitals but one, questionnaires were distributed by the hospital itself to all sections and departments of the hospital. This procedure was adopted because of hospital preference. Enough questionnaires to cover at least three-quarters of the personnel of each department were sent out. In Midland, the names of all personnel and staff were made available and a three-quarter sample was selected by the researcher. The hospitals were asked to follow the three-quarter sampling procedure for each department. All hospitals except South Eastern followed this procedure. In South Eastern, where the three-quarter sampling procedure for each department was not followed, those sections of the hospital performing hotel type functions were oversampled and the nursing administration and nursing care sections were undersampled. For this reason, and because the medical staff did not return their questionnaires, this hospital was dropped from the data analysis.

For purposes of the data analysis, only the data collected from the medical services and nursing administration divisions of the hospitals was analyzed. This procedure was adopted because these sectors of the organization represent the greatest single cost in personnel and equipment. They are also the most difficult sectors for the administrators to administrate, as was evident from the interviews and the division of labor between administrators and the assistant administrators. For example, the administrator in the smaller hospitals usually divided the administrative functions between himself and his assistant in such a way as to delegate responsibility for the hotel and maintenance sectors to the assistant, while retaining direct responsibility over nursing and medical service sectors. This is another major reason for selecting these sectors for analysis since they represent more immediate sources of influence on the administrator. Analysis of the areas of Hospital Operation questionnaire supported the rationale for this decision.

In all hospitals, the questionnaire was sealed inside a large brown envelope which also contained a smaller brown envelope addressed to the researcher. Respondents wer asked to complete the questionnaire and seal it in the smaller brown envelope. A central location, in three cases the personnel office and in one case the office of the administrator's secretary, was specified on the questionnaire as a drop-off point for hospital personnel and staff. In some cases, personnel chose to mail the questionnaire directly to the researcher.

Table 7 summarizes the number of respondents in the medical and nursing service sectors for the Hospital Organization questionnaire by organizational position.

Roles Conception questionnaire and Areas of Hospital Operation questionnaire. The administrator and his counter

TABLE 7
RETURN RATE FOR HOSPITAL ORGANIZATION QUESTIONNAIRE*

Nontechnical Worker	210
Technical Skilled	340
Technical Supervisors	25
Registered Nurses	366
Supervisors and Department Heads	141
Professional Staff	9
	1091

*A 50% return rate was achieved for each occupational category in the medical and nursing service sectors of each hospital.

role partners (assistant administrator, nursing director, medical director, personnel director, business manager) were asked to complete the Roles Conception and Areas of Hospital Operation questionnaires.

The Roles Conception questionnaire was also sent to the active medical staff of the participating hospitals and to the members of the boards of trustees. In both the Southern Religious and Southern Municipal hospitals, the physicians of the community have privileges in both hospitals and only one questionnaire was mailed to each physician. The return rate from physicians varied by hospital. A return rate of 45% was achieved for Urban hospital while for the combined hospital sample a return rate of 37% was obtained. Midland hospital achieved a return rate of 25%. In all cases the administrators felt that the physician's return rate was better than they had expected, and in one case felt that the return rate was higher than the physicians themselves had obtained for their own surveys. This does not, however, negate the bias in the results and sample. The results, therefore, must be interpreted with considerable caution.[45] On the other hand, it has been suggested by Larsen and Catton that the mail back bias, in some instances, may contribute to the validity of a study of this type, because it includes those who are most active and concerned with the operation of the hospital.[46] Indeed, the administrator in the pretest hospital pointed out the likelihood of a return bias. He suggested that he "probably knew" who would return the questionnaire, adding that these were the people who tended to be most active in the hospital and most relevant to him in his activities with the medical staff.

All questionnaires were mailed to the medical staff and the board of trustees and included a self-addressed, stamped envelope. An accompanying letter was also enclosed to explain the nature of the study, and to indicate that the project had the endorsement of the hospital administrator.

Roles Conception questionnaires were received from the following groups as shown in Table 8.

The Interviews. Interviews were conducted with the hospital administrator, his assistant if there was one, the director of nursing, the head of medical services and any other persons or staff in the technical sector that the administrator defined as important counter-role partners. It was not possible in all cases to conduct interviews with the chairman of the board of trustees. Table 9 summarizes the total number of interviews conducted, by respondent group.

IV. DATA ANALYSIS

All questionnaires were coded and the information punched onto cards. The data was checked for errors in coding and punching. Frequency counts were made on all the variables. While the cross-tabulations desired for the report had been established prior to the data collection phase, the frequency counts were used to determine if the categories to be used in the proposed tables were in fact suitable and possible.

TABLE 8
RETURN RATE FOR ROLES CONCEPTION QUESTIONNAIRE

Hospital Administrators	4
Administrative Counter role Assistants	13*
Physicians	119
Boards of Trustees	17

*Six of the department heads answered the Hospital Organizations questionnaire instead of the Roles Conception questionnaire.

TABLE 9
TOTAL NUMBER OF INTERVIEWS CONDUCTED BY RESPONDENT GROUP.

Hospital Administrators	4
Nursing Directors and Nursing Assistants	6
Medical Director or Equivalent (ie. Chief of Staff)	3
Assistant Administrators and Department Heads	10
Chairman of Board	3

Some modifications were made due to the possible lack of an appropriate N in some of the cells of the tables. Other table modifications were made in order to aid analysis of the large volume of material generated by the project.

The focus of the study presented a peculiar problem in data analysis. Because the study was directed at the hospital administrator, the integrity of the questionnaire data from these respondents had to be maintained. That is, it was undesireable to combine their responses with the other managerial groups. Thus, while the total sample of administrator responses has been left intact, it represents a very small number in relation to the numbers in the three other respondent groups. This situation arises, of course, due to the nature of the organizational structure at the upper administrative levels. The problem of a high rate of reduction in the number of cases as one moves up the organizational hierarchy is generally not dealt with in the literature as a research and data analysis problem. The problem may indeed be a consequence of the case study/survey design approach used in this project. Studies of supervisory staff generally avoid the problem either by combining groups, or focusing on a large number of organizations or set of organizations, where a sufficient number of cases can be assured. Except for a survey of a large number of administrators, the approach taken in this project will always tend to generate the problem encountered, and most statistical measures are not appropriate to this situation.

Ordinal measures of associations were used in the analysis of the hospital respondent data. Initially, Gamma, DXY, DYX and TAU' were calculated for each of the cross tabulations. DXY, however, was finally used as the main statistic in this study.

Gamma is an ordinal measure of association developed by Goodman and Kruskal. Freeman describes it as a measure of association "...between two sets of ordered observations based on their mutual predictability in terms of the number of agreements and inversions in the order of the rank."[47] It was decided not to report Gamma, however, due to the presence of ties. TAU' is equivalent to Gamma but is corrected for ties. Anderson and Zelditch point out that:

> ...it is a measure in which we assume that either X or Y might be dependent upon the other, and so we take both kinds of ties into account in the denominator. In practice, TAU' is probably the best measure to use.[48]

Like Gamma, TAU' and DXY may vary from +1.00 to -1.00, and indicate that the independent and dependent variables are positively or negatively associated.

Kendall's coefficient of concordance (W) was used to analyse the data from the Roles Conception questionnaire.[49] This is a non-parametric measure and is used to "...measure the relation among several rankings of N objects or individuals."[50] This measure expresses the degree of agreement among a set of judges with regard to a set of objects.

The median test was also computed. This is a nonparametric test, and:

> ...is a procedure for testing whether two independent

> groups differ in central tendencies. More precisely, the median test will give information as to whether it is likely that two independent groups (not necessarily of the same size) have been drawn from populations with the same median...the alternative hypothesis may be that the median of one population is different from that of the other (two-tailed test) or that the median of one population is higher than that of the other (one-tailed test). The test may be used whenever the scores for the two groups are in at least an ordinal scale.[51]

This test was used to analyze the data for the Roles Conception questionnaire.

V. THE HYPOTHESES

Ten propositions, and their supporting theoritical premises, were stated in Chapter II. Based upon the empirical indicators discussed above and used to operationalize the concepts stated in the propositions, the following hypotheses were developed to test the propositions.

Hypothesis One

> Professionalism is negatively related to bureaucratic hierarchy of authority, presence of rules, procedural specifications, and impersonality.

Hypothesis Two

> Professionalism is positively related to bureaucratic division of labour and technical competence.

Hypothesis Three

> Professionalism is positively related to negotiation.

Hypothesis Four

> Professionalism is positively related to committee decision-making.

Hypothesis Five

> Professionalism is positively related to interpersonal decision-making.

Hypothesis Six

Professionalism is positively related to role conflict, role ambiguity, and to total role conflict/ambiguity.

Hypothesis Seven

Role conflict and role ambiguity are positively related to negotiation.

Hypothesis Eight

Bureaucracy is negatively associated with negotiation.

Hypothesis Nine

The Kendall Coefficient of Concordance (W) will be higher for traditional than for nontraditional areas of administrator responsibility.

Corollary One

The average median response for all respondent groups will be between one and two for traditional areas and between two and four for nontraditional areas of hospital administrator responsibility.

Corollary Two

The deviation from the median will be larger for traditional than for nontraditional items.

Hypothesis Ten

The median response of the board of trustees to nontraditional areas of administrator responsibility will be lower than the median response of the medical staff.

FOOTNOTES

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11. Friedson, op.cit., p. 70.

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25. *Ibid.*, p. 73.

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CHAPTER IV

AN ANALYSIS OF PREDICTED RELATIONSHIPS

In this chapter, data will be presented to test the hypotheses related to organization structure. In addition, the relationships between negotiation and bureaucracy will be further explored by introducing some selected control factors which could influence the relationships. This additional analysis reflects the concern with bureaucracy and negotiation expressed in the review of the literature in Chapter II.

Hypothesis One

> Professionalism is negatively related to bureaucratic hierarchy of authority, presence of rules, procedural specifications and impersonality.

The discussion in Chapter II indicated an increasing recognition among organizational theorists that bureaucracy is not a unidimensional concept. In addition, the different dimensions of bureaucracy are thought to have either a positive or negative effect on professionalism. This is the rationale behind both Hypotheses One and Two.

Table 10 summarizes the correlations between professionalism and the four bureaucratic factors specified in Hypothesis One.

In only one instance, the hierarchy of authority, is there any relationship between bureaucracy and professionalism. This relationship is negative and supports Hypothesis One. The remaining three factors show no relationship with professionalism and do not, therefore, support the hypothesis.

TABLE 10
DXY CORRELATIONS BETWEEN PROFESSIONALISM AND BUREAUCRACY

Bureaucratic Dimension	Dxy
Hierarchy of Authority	-.21
Rules for Encumbents	.03
Procedural Specifications	-.04
Impersonality	-.009

It would appear from this data that, the more role encumbents exhibit professional characteristics, the less likely are organizations to exhibit a structured hierarchy of authority. Professionalism is not related to bureaucratic rules, procedural specifications, and impersonality, in the four hospitals studied in this project.

Hypothesis Two

> Professionalism is positively related to bureaucratic division of labour and technical competency.

Table 11 summarizes the Dxy correlations to test Hypothesis Two.

It is apparent from Table 11 that there is no support for Hypothesis Two. In addition, the data indicate that, the more role encumbents exhibit professional characteristics, the less likely are these acute care institutions to maintain a distinct division of labour among its members. This is contrary to what was expected. Bureaucratic demands for technical competency apparently are not related to professionalism among role encumbents.

In summarizing the results from Hypotheses One and Two, it is apparent that, in increasing the extent to which role encumbents exhibit professional traits, the less likely are these organizations to structure authority or the division of labour. This inhibitory effect may be due to the fact that professional lines of authority, which are colleagial or horizontal, are contrary to hierarchical distinctions in authority. In addition, increasing occupational and task distinc-

TABLE 11
DXY CORRELATIONS BETWEEN PROFESSIONALISM AND BUREAUCRACY

Bureaucratic Dimension	Dxy
Division of Labour	-.17
Technical Competence	.07

tions among work groups may be contrary to collegial types of relationships and to the work demands on the personnel to perform as "teams" in hospital settings.

Professionalism is not related to bureaucratic rules for encumbents, procedural specifications, impersonality, and demands for technical competency

Hypothesis Three

Professionalism is positively related to negotiation.

A positive relationship between professionalism and each of the five negotiatory elements has been predicted since organizational theorists have suggested that professionals are most likely to interact with each other in this way. The basis of this argument appears to lie in the nature of the relationships and authority among professionals. That is, "collegial relationships" and "advisory bureaucracies" would seem to be based on negotiatory behavior. While negotiatory behavior may occur among less professionalized personnel, and between subordinates and superordinates in an organization, the imposition of power and status differentials tends to reduce communication and interpersonal contact, thereby reducing the extent of negotiative behavior.

It is evident from Table 12 that while all associations are positive as predicted, only the association between professionalism and committee negotiation is of any magnitude. Professionals are more likely than nonprofessionals to engage in committee negotiation, and are neither more nor less likely to engage in agreements, rules, task, or interdepartmental nego-

TABLE 12
DXY CORRELATIONS BETWEEN PROFESSIONALISM AND NEGOTIATION

Negotiation Dimension	DXY
Agreements	.04
Rules	.06
Committee	.21
Task	.02
Interdepartmental	.06

tiation.

In sum, there is no confirmation for Hypothesis Three except for the positive relationship between professionalism and committee negotiation. This would suggest that negotiatory behavior tends to be localized and occurs most frequently among professionals in formal "arenas." The comments of the administrator of Urban Hospital would appear to be relevant here, in that he recognized the "need for conflicts," but also the importance of establishing "...situations where conflict and different points of view could be ironed out without disrupting the whole organization."

Hypothesis Four

> Professionalism is positively related to committee decision-making.

While there is some support for Hypothesis Four, as indicated in Table 13, the Dxy correlation is not particularly strong. The sign of the relationship, however, is in the direction predicted.

For those organizational members exhibiting low professionalism, their involvement in decision-making in any of the departmental committees tends to be low. Only one fifth indicated that they were highly involved in the decisions made within departmental committees. Organizational participants exhibiting medium to high professionalism indicated that their involvement in decision-making in departmental committees increases from low to medium levels, and then decreases. The involvement of medium and highly professionalized role en-

TABLE 13
PROFESSIONALISM BY
INTRA-DEPARTMENTAL COMMITTEE DECISION-MAKING

	Low		Medium		High		Total	
Professionalism	N	%	N	%	N	%	N	%
Low	163	.52	89	.28	62	.20	314	100.0
Medium	147	.28	216	.42	157	.30	520	100.0
High	44	.32	59	.42	37	.26	140	100.0
Total	354	.36	364	.38	256	.26	974	100.0

DXY = .16

cumbents is curvilinear.

Hypothesis Five

> Professionalism is positively related to interpersonal decision-making.

As indicated in Table 14, there is no support for Hypothesis Five. Professionals are no more likely to engage in informal decision-making than nonprofessionals. Furthermore, participation in informal or interpersonal decision-making increases to a medium level for all levels of professionalism and decreases thereafter. Approximately only one third of the personnel, irrespective of level of professionalism, actively participate in this form of decision-making.

Hypothesis Six

> Professionalism is positively related to total role conflict, total role ambiguity and total role conflict/ambiguity.

Some analysts have suggested that professionals in organizations are most likely to experience role conflict and ambiguity.[1] Others have indicated that this relationship does not always occur.[2]

As is evident from Tables 15, 16, and 17, there is no support for Hypothesis Six. Professionals are no more or less likely to experience role strain than nonprofessionals. For both role conflict and role ambiguity, and for respondents at all levels of professionalism, the experience of role strain increases to medium levels and decreases thereafter.

Hypothesis Seven

Role conflict and ambiguity are positively related to

TABLE 14
PROFESSIONALISM BY
INTERPERSONAL DECISION-MAKING

Professionalism	Low		Medium		High		Total	
	N	%	N	%	N	%	N	%
Low	80	.24	132	.40	121	.36	333	100.0
Medium	110	.22	230	.46	55	.32	495	100.0
High	26	.19	67	.48	46	.33	139	100.0
Total	216	.22	429	.44	322	.34	967	100.0

DXY = -.004

TABLE 15
PROFESSIONALISM BY
TOTAL ROLE CONFLICT

Professionalism	Low		Medium		High		Total	
	N	%	N	%	N	%	N	%
Low	101	.31	203	.62	21	.07	325	100.0
Medium	174	.33	326	.61	31	.06	531	100.0
High	35	.25	98	.69	9	.06	142	100.0
Total	310	.31	627	.63	61	.06	998	100.0

DXY = .01

TABLE 16
PROFESSIONALISM BY
TOTAL ROLE AMBIGUITY

Professionalism	Low		Medium		High		Total	
	N	%	N	%	N	%	N	%
Low	162	.50	146	.45	18	.05	326	100.0
Medium	231	.43	263	.49	39	.08	533	100.0
High	60	.42	68	.48	14	.10	142	100.0
Total	453	.45	477	.48	71	.07	1001	1-0.0

DXY = .06

TABLE 17
PROFESSIONALISM BY TOTAL ROLE CONFLICT AND AMBIGUITY

Professionalism	Low		Medium		High		Total	
	N	%	N	%	N	%	N	%
Low	187	.57	113	.35	26	.08	326	100.0
Medium	277	.52	204	.39	49	.09	530	100.0
High	67	.46	60	.42	17	.12	144	100.0
Total	531	.53	377	.38	92	.09	1000	100.0

DXY = .07

negotiation.

This hypothesis is derived from the assumption that role conflict and ambiguity are unpleasant experiential states which role encumbents attempt to reduce. Role conflict and role ambiguity stem from the social structure in which encumbents are located.[3] Role conflict and ambiguity, however, are theoretically the intervening variables between social structure and "interpretive" behavior designed to reduce these unpleasant states.[4] The negotiation, or renogotiation, of expectations is one means system actors have to reduce such states.

Table 18 summarizes the associations between role conflict, role ambiguity, and negotiation. There is no support for the hypothesis. Role conflict and ambiguity are not related to negotiatory behavior, and therefore do not appear to induce negotiatiory behavior.

Hypothesis Eight

Bureaucracy is negatively associated with negotiation.

Frank has argued that in organizations in which roles are overdefined and underdefined, role encumbents will engage in role-making behavior.[5] On the other hand, Strauss has argued that negotiatory behavior is characteristic of all organizations.[6]

Rushing has argued that, as organizations increase their structural differentiation, the use of rules and regulations will tend to increase and replace surveillance.[7] This argument implies that accomodative behavior will not occur, in

TABLE 18
DXY ASSOCIATIONS FOR THE RELATIONSHIPS BETWEEN ROLE CONFLICT, ROLE AMBIGUITY, TOTAL ROLE CONFLICT AND AMBIGUITY, AND NEGOTIATION

	Agreements	Rule	Committee	Task	Interdepartmental
Role Conflict	.02	.008	-.02	.09	.05
Role Ambiguity	-.07	-.02	-.06	-.01	-.02
Role Conflict and Ambiguity	-.02	-.02	-.04	.01	.02

contrast to Frank's prediction, because tasks are clearly defined. Rushing also assumes that the rules are neither excessive or conflicting. In this situation, the organization would be "well-defined" according to Frank, and accomodative behavior would not occur. As Frank points out, however, the well-defined organization rarely occurs. Rushing's argument also does not take into account the variety in types of differentiation and causes of differentiation.[8] For example, differentiation may be a response to environmental uncertainty, which tends to decrease the likelihood that rules can or will be used.[9] Nevertheless, Rushing's argument provides a beginning point to raise the question whether increasing degrees of bureaucracy decreases or increases the likelihood of negotiative behavior occurring.

Table 19 summarizes the associations among the bureaucratic factors and the negotiation factors. A negative sign has been predicted for each of the associations.

Contrary to expectations, bureaucratic authority, procedural specifications, and impersonality were positively associated with agreement negotiation, and impersonality was positively related to interdepartmental negotiation. Increasing levels of technical competency also increased the likelihood that negotiation in formal arenas would occur.

While these positive associations are contrary to Hypoththesis Eight, they do provide support for Frank's contention that increasing degrees of bureaucracy tend to increase the likelihood that organizational members will engage in accommodative role-making behavior. As Frank has pointed out, and

TABLE 19
DXY CORRELATIONS BETWEEN BUREAUCRATIC FACTORS AND NEGOTIATION FACTORS

Bureaucratic Factors	Negotiation Factors Agreements	Rule	Committee	Task	Inter-Department
Authority	.04	.08	-.05	.21	.04
Division of Labour	-.03	.02	-.14	.03	-.01
Rules for Incumbents	.15	-.04	.06	.08	.03
Procedural Specifications	.05	.08	.09	.12	.03
Impersonality	.03	.0[illegible]	.001	.11	.14
Technical Competency	.09	.08	.17	.04	.09

Rushing has neglected to consider, this may be due either to the absence of rules, regulations or norms (underdefined organizations), or to the excess of such organizational paraphernalia (the overdefined organization).

The data also tend to support Strauss'[15] argument that bureaucracies provide the grounds for negotiation. On the other hand, the data also suggest that specific dimensions of bureaucracy tend to affect only certain types of negotiatory behavior, and not all types.

Only the small negative association between bureaucratic division of labour and committee negotiation provides some weak support for Hypothesis Eight. Apparently, increasing task differentiation in an organization is negatively associated with negotiatory behavior in formal arenas.

As shown earlier, this bureaucratic factor was also negatively associated with professionalism in these hospitals. While this element of bureaucracy, therefore, is negatively associated with professionalism and committee negotiation, it has been shown that professionalism is positively associated with negotiation in formal arenas. Thus, while professionalism tends to increase with increasing negotiatory behavior in formal arenas, as suggested by Bucher and Stelling,[10] this dimension of bureaucracy is negatively associated with accommodative behavior, both directly and indirectly.

This pattern suggests that Strauss and his colleagues, in attempting to generalize the applicability of their theory to all organizations, were correct in arguing that negotiation was most likely to occur in organizations in which there were professionals. They were incorrect, however, in claiming that negotiation would also be more likely to occur in organizations which "...(utilize) personnel trained in several different occupations," and who therefore performed different tasks.[11] The data indicate that the division of labour is directly and negatively associated with negotiation, as well as indirectly by negatively affecting professionalism.

The data also indicate that a fairly high degree of negotiation occurs in creating the "everyday understandings" that develop over and above ruled or task directed behavior. While the highly professionalized worker is somewhat more likely to engage in this type of interpersonal activity than the less professionalized, the difference is not very large. In contrast, negotiation over rules and tasks tends to be low. These would appear to be areas that are non-negotiable, at least in general hospitals where technologies are explicit, and hence, also the rules and the delegation of tasks. Indeed, members of these organizations do tend to experience a high degree of bureaucratic rules, although, surprisingly, a low degree of division of labour and procedural specifications.

This data is also in contrast to the findings of Strauss and his colleagues. The differences in negotiation over tasks and rules may be due to the level of specificity in technologies employed in the two settings. In general hospitals, except for such controversies as the mobilization of cardiac patients, treatment technologies are generally not open to debate.[12] In the mental hospital, treatment technologies are debatable, and as Strauss points out, "...as the teams discussed treatment ideologies and evaluated their own activities, they also defined necessary tasks."[13]

On the other hand, while the bureaucratic division of labour negatively affects negotiation in committees, bureaucratic demands for technical competency have a positive effect in increasing committee negotiation. These findings parallel those of Hall's regarding the effect of bureaucracy on professionalism.[14] That is to say, the specific dimensions of bureaucracy have different effects and not a consistently negative effect as many writers have claimed. As Hall has pointed out, this generalized negative effect occurs because bureaucracy is usually conceived of as a holistic concept, and not as a multi-dimensional concept as Weber intended.

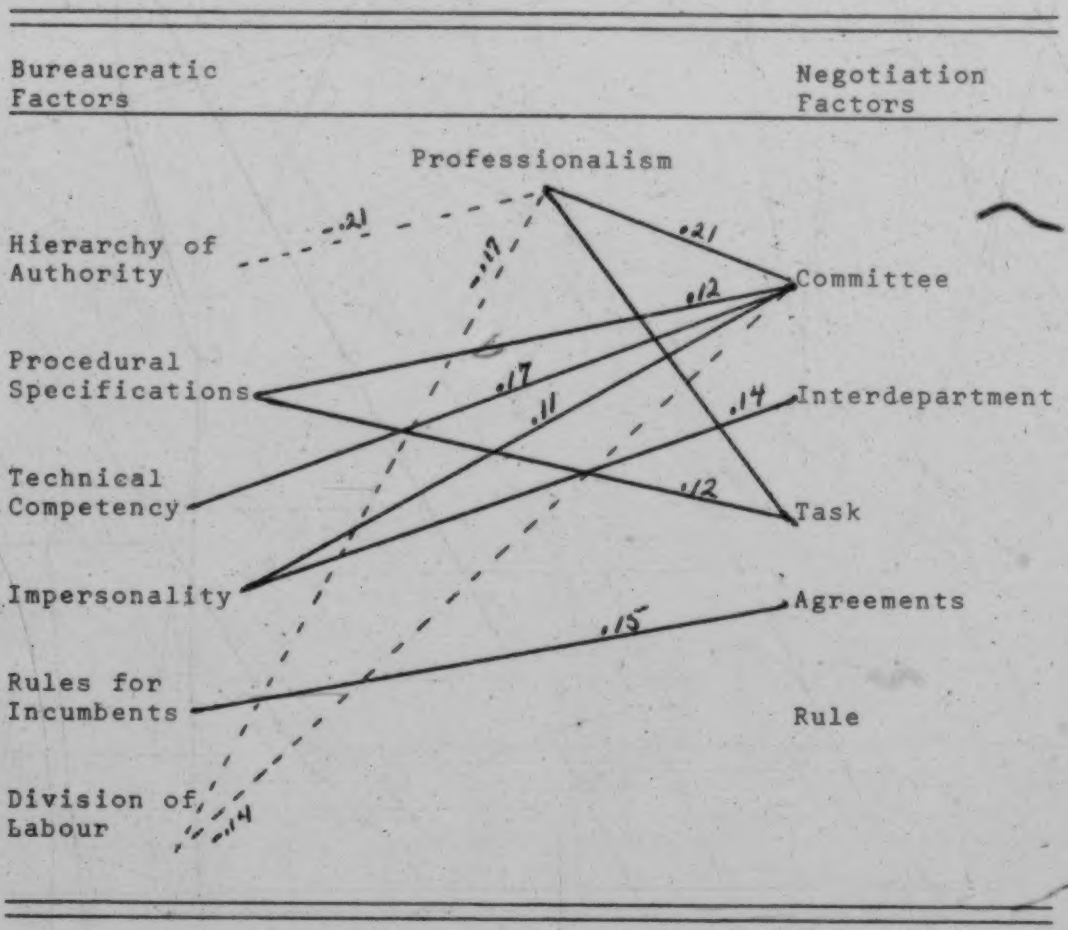
The discussion above and the interrelationships among the bureaucratic and negotiatory dimensions are summarized in Figure 1.

Further Exploration of the Relationships Between Negotiation and Bureaucracy

In an effort to determine if the relationships between bureaucracy and negotiation were affected by other factors, a series of test factors were applied to the relationships.

Professionalism, interpersonal and committee decision-making, and the three supervisory skills - technical, human relations, and administrative - were selected as test factors. These test factors were selected because they may, theoretically,

FIGURE ONE
SUMMARY OF DXY ASSOCIATIONS AMONG THE BUREAUCRATIC AND NEGOTIATION FACTORS, INCLUDING PROFESSIONALISM



-------- indicates a negative (-) relationship
________ indicates a positive (+) relationship

affect the relationships between bureaucracy and negotiation.

Despite the lack of correlation in most cases between professionalism and negotiation and between professionalism and bureaucracy, it was felt that the concern expressed about this variable in the literature justified further explorative efforts. The two decision-making modes were selected in the belief that the settings and manner by which decision-making occurs, could affect the accommodative behavior in relation to bureaucracy. Finally, the supervisory skills were selected due to the central importance that leadership and styles of supervision are generally shown to have on organizational behavior.

Table 20 reports the correlations between bureaucracy and negotiation, controlling for professionalism.

The relationships between agreements negotiation and the six bureaucratic dimensions tend to remain the same, irrespective of the condition of the test factor. This is also true for rule negotiation, except for the slight positive increase, under conditions of low and high professionalism, in the strength of the relationship with the hierarchy of authority. The original positive relationship between committee negotiation and technical competency tends to increase under conditions of high professionalism. Finally, increasing procedural specification is more strongly and positively associated with task negotiation when professionalism is high.

In general, professionalism as a test factor appears to have only a slight influence on the relationships between negotiation and bureaucracy. This may be due to the fact that

TABLE 20
CORRELATION BETWEEN BUREAUCRACY AND NEGOTIATION CONTROLLING FOR PROFESSIONALISM

		Negotiation Factors				
Bureaucratic Factors	Control Value	Agreements	Rule	Committee	Task	Inter-departmental
Hierarchy of Authority	Low	.009	.16	.10	.17	.05
	Medium	.09	.07	-.08	.25	.04
	High	-.03	.13	.05	.27	.002
Division of Labour	Low	-.03	.07	-.12	.01	.002
	Medium	.01	.02	-.05	.07	-.04
	High	.06	.009	-.07	-.13	.06
Rules for Encumbents	Low	.18	.08	.07	.15	.08
	Medium	.13	.009	.01	.07	.01
	High	.21	-.09	.06	.02	-.005
Procedural Specifications	Low	-.02	.10	.10	.13	.03
	Medium	.09	.08	.08	.09	.04
	High	.08	.12	.09	.21	-.02
Impersonality	Low	-.04	.04	.02	.05	.13
	Medium	.09	.02	.01	.13	.08
	High	.02	.06	.01	.10	-.08
Technical Competency	Low	.13	.07	.14	.07	.07
	Medium	.08	.11	.12	-.03	.08
	High	.09	.10	.27	.13	.05

professionalism is related to only one of the negotiation indices, and to only two of the bureaucratic indices.

Table 21 summarizes the correlations between negotiation and bureaucracy, controlling for interpersonal decision-making.

In most cases, this test factor appears to have little influence on the original relationships. There are, however, five instances where the relationships are altered. Under conditions of low interpersonal decision-making, increasing the bureaucratic hierarchy of authority increases rule negotiation. Under conditions of high informal decision-making, increasing rules for encumbents increases agreements negotiation, while slightly lowering the strength of the association under medium conditions.

Only when interpersonal decision-making is high, is there a slightly positive relationship between bureaucratic impersonality and agreements negotiation. The strength of the positive relationship between bureaucratic impersonality and task negotiation increases slightly when interpersonal decision-making is low, and is reduced nearly to zero under medium conditions. While the relationship between bureaucratic impersonality and interdepartmental negotiation is retained when interpersonal decision-making is low, the relationship is reduced to nearly zero under medium and high conditions.

Table 22 summarizes the associations between negotiation and bureaucracy, controlling for committee decision-

TABLE 21
CORRELATION BETWEEN BUREAUCRACY AND NEGOTIATION CONTROLLING FOR INTERPERSONAL DECISION-MAKING

		Negotiation Factors				
Bureaucratic Factors	Control Value	Agreements	Rule	Committee	Task	Interdepartmental
Hierarchy of Authority	Low	.05	.22	-.02	.25	.10
	Medium	-.01	.01	.002	.21	.01
	High	.08	.06	-.11	.15	-.01
Division of Labor	Low	-.06	.05	-.07	.05	-.10
	Medium	-.04	-.02	-.10	-.009	.005
	High	.03	.05	-.12	.01	-.03
Rules for Encumbents	Low	.14	-.01	-.03	.12	.12
	Medium	.10	.02	.11	.08	-.06
	High	.21	-.01	.04	.06	.08
Procedural Specifications	Low	.03	.14	.12	.13	.007
	Medium	.02	.05	.11	.15	.08
	High	.08	.09	.05	.06	-.01
Impersonality	Low	-.01	.04	.002	.20	.14
	Medium	-.02	.007	.02	.009	.01
	High	.13	.04	-.02	.13	.07
Technical Competency	Low	.09	.005	.13	-.01	-.03
	Medium	.11	.12	.17	.03	.11
	High	.11	.09	.13	-.001	.10

TABLE 22

CORRELATION BETWEEN BUREAUCRACY AND NEGOTIATION CONTROLLING FOR COMMITTEE DECISION-MAKING

		Negotiation Factors				
Bureaucratic Factors	Control Value	Agreements	Rule	Committee	Task	Interdepartmental
Hierarchy of Authority	Low	.007	.12	-.009	.25	.01
	Medium	.04	.03	-.04	.19	.04
	High	.06	.06	-.08	.20	-.008
Division of Labor	Low	-.07	.05	-.06	.07	.06
	Medium	.002	.04	-.09	.007	.01
	High	.01	-.04	-.15	-.009	-.14
Rules for Encumbents	Low	.19	.03	.08	.09	.01
	Medium	.08	.02	-.02	.04	-.02
	High	.17	-.06	.11	.13	.07
Procedural Specifications	Low	.04	.11	.07	.17	.07
	Medium	.07	.08	.08	.10	.02
	High	.009	.02	.11	.11	-.004
Impersonality	Low	-.03	-.002	-.03	.07	.04
	Medium	.06	.09	.01	.10	.08
	High	.04	-.02	.02	.12	.06
Technical Competency	Low	.09	.09	.16	.07	.09
	Medium	.10	.04	.12	-.03	.009
	High	.07	.16	.16	.01	.15

making.

As with professionalism and interpersonal decision-making, this test factor has little effect on the original relationships. In those cases where there is any notable effect, it is generally to reduce the strength of the association to nearly zero. Under low and medium levels of committee decision-making, the relationships between the division of labour and committee negotiation, and between technical competency and rule negotiation, are reduced to zero. The relationship is maintained under high committee decision-making. The test factor, committee decision-making, appears to account for the original relationship between bureaucratic impersonality and interdepartmental negotiation.

As can be seen in Tables 23 and 24, the relationship between certain bureaucratic and negotiation factors tends to be suppressed when supervisory technical and human relations skills are low. In contrast, Table 25 indicates that the relationships between certain bureaucratic and negotiation factors are suppressed when supervisors' administrative skills are rated as high by the respondents.

When supervisors' technical skills are rated as low, a stronger negative relationship is apparent between the bureaucratic division of labour, and rules, committee and interdepartmental negotiation. Increasing the extent of objective task differences is most likely to be negatively associated with negotiation when supervisors' are rated as poor in technical skills. This situation also appears to

TABLE 23
CORRELATION BETWEEN BUREAUCRACY AND NEGOTIATION CONTROLLING FOR SUPERVISOR'S TECHNICAL SKILLS

		Negotiation Factors				
Bureaucratic Factors	Control Value	Agreements	Rule	Committee	Task	Interdepartmental
Hierarchy of Authority	Low	-.08	.05	-.09	.22	.08
	Medium	.06	.13	-.13	.17	.07
	High	.04	.06	-.01	.22	.008
Division of Labor	Low	.05	-.29	-.29	.01	-.24
	Medium	-.01	.09	-.14	-.001	.06
	High	-.02	.01	-.08	.02	-.02
Rules for Encumbents	Low	.28	.10	.11	-.05	-.07
	Medium	.14	.06	.03	.15	.19
	High	.14	-.01	.05	.07	-.01
Procedural Specifications	Low	.05	.06	.04	.10	.12
	Medium	.13	.18	.09	.14	.03
	High	.02	.04	.08	.10	.02
Impersonality	Low	.05	.00	-.07	.00	-.24
	Medium	.02	.04	-.008	-.002	.03
	High	.03	.02	.007	.13	.09
Technical Competency	Low	.19	.09	.36	.27	-.03
	Medium	.16	.07	.18	.05	.11
	High	.07	.09	.13	-.01	.07

TABLE 24
CORRELATION BETWEEN BUREAUCRACY AND NEGOTIATION CONTROLLING FOR SUPERVISOR'S HUMAN RELATIONS SKILLS

		Negotiation Factors				
Bureaucratic Factors	Control Value	Agreements	Rule	Committee	Task	Interdepartmental
Hierarchy of Authority	Low	-.01	0.08	-.11	.39	.09
	Medium	.02	.12	-.02	.16	.05
	High	.05	.07	-.04	.20	.01
Division of Labor	Low	.20	-.14	-.07	.06	.15
	Medium	-.03	.08	-.21	.01	.04
	High	-.03	.03	-.07	.01	-.03
Rules for Encumbents	Low	.13	.14	.07	-.03	.02
	Medium	.14	.005	.03	.05	.08
	High	.15	.00	.05	.10	.01
Procedural Specifications	Low	.31	.13	.09	.42	.20
	Medium	.05	.26	.12	.13	.11
	High	.03	.02	.07	.09	-.004
Impersonality	Low	-.13	.11	-.13	.05	-.16
	Medium	-.004	-.01	.02	-.004	.06
	High	.04	.04	.003	.13	.08
Technical Competency	Low	.26	.16	.17	.10	-.07
	Medium	.11	.07	.17	.06	.05
	High	.08	.10	.14	.006	.09

hold true for the relationship between bureaucratic impersonality and interdepartmental negotiation.

When supervisors' skills are rated as low, however, a slightly stronger positive relationship is revealed between bureaucratic rules and agreements negotiation. This is also true for the relationship between bureaucratic demands for technical competency, and committee and task negotiation. When supervisory technical skills are rated as low, bureaucracy is associated with decreased formal and increased informal negotiation.

As illustrated in Table 24, when supervisors' human relations skills are rated as low, a stronger positive relationship is revealed between the following bureaucratic and negotiative factors: hierarchy of authority and task negotiation; division of labour and agreements negotiation; bureaucratic rules and rule negotiation; procedural specifications and agreements, rule, task and interdepartmental negotiation; and finally, between technical competency and agreements negotiation. It would appear that when the supervisors' human relations skills are poor, the need increases for role encumbents to develop accomodations informally, between departments, and over rules and tasks.

Table 25 summarizes the associations between bureaucracy and negotiation, controlling for supervisors' administrative skills.

When supervisors' administrative skills are rated as high, a stronger positive relationship is revealed between rule negotiation and the hierarchy of authority, procedural

TABLE 25
CORRELATION BETWEEN BUREAUCRACY AND NEGOTIATION CONTROLLING FOR SUPERVISOR'S ADMINISTRATIVE SKILLS

		Negotiation Factors				
Bureaucratic Factors	Control Value	Agreements	Rule	Committee	Task	Interdepartmental
Hierarchy of Authority	Low	.001	.03	-.04	.21	.06
	Medium	.08	.10	-.02	.19	-.008
	High	.08	.37	.08	-.08	.04
Division of Labor	Low	-.03	.02	-.17	.03	.01
	Medium	.004	.008	-.007	.002	-.03
	High	-.25	.09	.14	-.21	-.26
Rules for Encumbents	Low	.16	.04	.10	.08	.02
	Medium	.12	-.04	-.02	.09	.02
	High	.12	-.01	.02	-.03	.20
Procedural Specifications	Low	.04	.03	.08	.14	-.003
	Medium	.06	.12	.08	.09	.09
	High	-.20	.37	.02	-.16	-.29
Impersonality	Low	.02	.06	-.008	.11	.08
	Medium	.05	-.02	.02	.07	.04
	High	-.23	.14	-.01	.02	.00
Technical Competency	Low	.12	.08	.15	.02	.08
	Medium	.06	.12	.10	.01	.06
	High	-.08	.03	-.07	.15	.08

specifications, and impersonality. High administrative skills may either stimulate rule negotiation because the "bureaucratic" nature of the skill involves increasing hierarchical distinctions, procedural specifications and impersonality, or such skills may possibly facilitate this type of negotiation.

When supervisors' administrative skills are rated as high, a stronger negative relationship is revealed between agreements negotiation and the three bureaucratic factors - division of labour, procedural specifications, and impersonality. The original relationships were nearly zero. It would appear that when the administrative skills of supervisors are rated as high, increasing bureaucracy decreases the extent to which informal accomodations are made among role encumbents. This may indicate that high administrative skills of supervisors reduce the need for such accomodations - hence resulting in a well-defined organization - or else impedes this type of accomodative behavior.

The fact that rule negotiation increases when supervisors' administrative skills are rated as high, and informal accomodations decrease under the same conditions, suggests a selective facilitating role of such skills. That is, the need for informal agreements is reduced by redirecting efforts at accomodative behavior towards specific objectives. The direct negotiation of rules, rather than establishing informal agreements, would improve the possibilities for coordination. Since supervisory administrative skills are very strongly and positively related to intradepartmental coordination, this interpretation has some systemic support within this study. Mann and Georgopoulos have also indicated that the higher the supervisors' skills in these areas, the better the patient care and the more employees direct their communications toward task related activities.[15] Their findings, therefore, also lend support to the interpretation presented above.

When administrative skills are rated as medium, the relationship between committee negotiation and the division of labour is reduced to zero. In addition, the relationships between task negotiation and the division of labour, and between committee negotiation and technical competency, are reduced to zero when administrative skills are rated as high. In these instances, medium or high administrative skills appear to account for the original relationships.

When administrative skills are rated as high, a negative association is revealed between task negotiation and the division of labour and procedural specifications. A positive relationship occurs with technical competency. Negative associations are also revealed for the relationships between interdepartmental negotiation and the division of labour, and procedural specification, when administrative skills are high. Where negative associations are apparent in four instances, it would appear that high administrative skills may either reduce the need for, or impede the accomodation to bureaucracy. However, in part because the relationship is positive between task negotiation and technical competency, and in part because high administrative skills could be expected to improve coordination among task areas and between departments (indeed, the association between administrative skills of the supervisor and coordination is strongly positive), the interpretation that such skills may reduce the need for accomodative behavior would seem to be more consistent with the data.

In summary, high administrative skills appear to reduce the need for and the relationship between agreements, task and interdepartmental negotiation and bureaucracy, while positively affecting the relationship for rule negotiation.

This latter section has suggested that professionalism and the two decision-making modes appear not to affect the original relationships between negotiation and bureaucracy. Low supervisory technical and human relations skills appear to impede formal and stimulate informal accomodative behavior, with increasing bureaucracy. In contrast, high supervisory administrative skills appear to reduce the need for negotiation while stimulating the relationship between rule negotiation and bureaucracy.

With regard to supervisory skills, however, these latter findings must be dealt with cautiously. Due to the number of cells created through controlling for each of the three supervisory skills, there is a large reduction in the numbers in certain cells. This is particularly the case under low technical and human relations skills, and high administrative skills. Since the N in each case is approximately 18, the alterations in the correlations may be a function of chance variation due to the small number of cases.

Summary

This chapter tested eight hypotheses and further explored the relationship between negotiation and bureaucracy, controlling for six test factors.

Professionalism was found to be negatively related to bureaucratic hierarchy of authority and to the division of labour. Professionalism was positively related to committee negotiation, but not to any of the other negotiation factors.

Professionalism was also found to be positively related to committee decision-making. Interpersonal decision-making was not related to professionalism. Furthermore, role conflict and ambiguity were not related to either negotiation or professionalism.

While the bureaucratic division of labour was negatively correlated with committee negotiation, six positive associations were obtained, indicating that specific aspects of bureaucracy tended to increase specific forms of negotiation. This was contrary expectation.

Professionalism, interpersonal decision-making and committee decision-making, while altering the value of the original relationships between bureaucracy and negotiation in a few instances, did not appear to have any major significant and consistent effects.

When supervisors' technical skills are rated as low, the division of labour is negatively associated with rules, committee and interdepartmental negation. Bureaucratic impersonality is also negatively associated with interdepartmental negotiation. On the other hand, under low technical supervisory skill conditions, bureaucratic rules are positively associated with agreements negotiation, and bureaucratic demands for technical competency are positively associated with committee and task negotiation.

When supervisors' human relations skills are rated as low, the following positive associations between bureaucracy and negotiation become apparent: hierarchy of authority and task negotiation; division of labour and agreements negotiation; bureaucratic rules and rules negotiation; and bureaucratic procedures with agreements, rule, task and interdepartmental negotiation.

Under conditions of high administrative skills, a negative relationship appears to exist between bureaucracy and negotiation. These findings, however, should be considered as tentative in view of the small N on which the findings are based. They do suggest that different supervisory skills and styles have different effects on organizational behavior. The data to be presented in Chapter V also suggest this, and indicate the need for additional research into the indirect effects of supervision on organizational structure and behavior.

FOOTNOTES

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9. P.R. Lawrence and J.W. Lorsch, *Organization and Environment: Managing Differentiation and Integration* (Illinois: Richard D. Irwin, Inc., 1969).

10. Rue Bucher and Joan Stelling, "Characteristics of Professional Organizations," *Journal of Health and Social Behavior*, 10(March, 1969), pp. 3-15.

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12. Amsa B. Ford and Sidney Katz, "Prognosis After Strokes: Part I, A Critical Review," *Medicine* 45(1966), pp. 223-236.

13. A. Strauss, *et.al.*, *Psychiatric Ideologies and Institutions* (New York: Free Press, 1964), p. 157.

14. R. Hall, "Professionalism and Bureaucratization; *op.cit.*,

pp. 102-103.

15. B.S. Georgopoulos and F.C. Mann, The Community General Hospital (New York: MacMillan, 1962).

CHAPTER V

ORGANIZATIONAL CLIMATES AND CONTEXTS OF THE HOSPITAL ADMINISTRATORS

I. AN OVERVIEW OF ORGANIZATIONAL CONTEXTS

Organizations are both similar and dissimilar. In this first part of the chapter, an attempt is made to characterize the similarities in the type of organizational climates that exist across hospitals. Specific variations within each of the hospitals, and their effects on the administrator's behavior, are discussed in the latter part of this chapter.

In general, the organizational climates of all the hospital organizations in the study can be described as positive. That is, there is a tendency for all hospital personnel to evaluate their hospitals favourably on most of the organizational variables.

The full significance of this generalization will be elaborated later. It is important to emphasize here, however, that establishing the empirical existence of a positive organizational climate across organizations of a similar "type," has direct implications for the form of administrative processes which the administrators in the study tended to use or were moving towards. The organizational climates confronting all the administrators tended to support, and were in turn supported by, "participative" styles of administrative behavior. *While it is important to describe the effect particular organizational contexts have on a particular administrator, it is just as important to derive whatever generalizations the data permit concerning administrative behavior and organizational context*. This makes possible the opportunity to discuss generalizations about organizations and administrator behavior that are otherwise not possible if one focuses upon only the unique characteristics of situations and administrators.

Table 26 summarizes the frequency and percentage distributions for the selected organizational factors. This table best describes the favourable organizational climates that exist across hospitals. It is evident from variable one in Table 26, that the four administrators' belief was confirmed that most of their personnel participated in committee decision-making. Indeed, two thirds of the hospital personnel indicated a medium to high level of participation in such formal settings. Furthermore, nearly three quarters indicated a medium to high level of involvement in decision-making in informal interpersonal settings.

Supervisors tended to be rated highly on technical, human relations and administrative skills. It is evident, however, in comparing the evaluation of the three supervisors' skills, that the respondents were slightly more critical of the administrative skills of their supervisors than of the other two supervisory skills. Further evidence of the

TABLE 26
PERCENTAGE AND FREQUENCY DISTRIBUTION OF THE ORGANIZATIONAL VARIABLES FOR ALL HOSPITALS

Organizational Variable		Low		Medium		High		No Answer		Total	
		N	%	N	%	N	%	N	%	N	%
1.	Intradepartmental Committee Decision-Making	355	32.5	426	39.0	278	25.4	32	2.9	1091	100.0
2.	Interpersonal Decision-Making	241	22.0	459	42.0	355	32.5	36	3.2	1091	100.0
3.	Supervisor's Skills										
3a.	Technical	42	3.8	220	20.1	814	74.6	15	1.3	1091	100.0
3b.	Human Relations	38	3.4	237	21.7	810	74.2	6	0.5	1091	100.0
3c.	Administrative	100	9.1	236	21.6	745	68.2	10	0.9	1091	100.0
4.	Total Job Satisfaction	30	2.7	449	41.4	605	55.8	3	0.1	1091	100.0
4a.	Supervision	86	7.8	245	22.4	745	68.2	15	1.3	1091	100.0
4b.	Promotion	374	34.2	293	26.8	362	33.1	62	5.6	1091	100.0
4c.	Income	248	22.7	375	34.3	459	42.0	0	0.8	1091	100.0
4d.	Working Conditions	70	6.4	353	32.3	653	59.8	15	1.3	1091	100.0
4e.	Opportunity for Work Decisions	96	8.7	300	27.4	683	62.6	12	1.0	1091	100.0
4f.	Working Relations	25	2.2	199	18.2	859	78.7	8	0.7	1091	100.0
5.	Intradepartmental Relations	11	1.0	314	28.7	757	69.3	9	0.8	1091	100.0
6.	Intradepartmental Coordination	18	1.6	233	21.3	817	74.8	23	2.1	1091	100.0
7.	Role Conflict	343	31.4	676	61.9	64	5.8	8	0.7	1091	100.0
8.	Role Ambiguity	497	45.5	510	46.7	80	7.3	4	0.3	1091	100.0
9.	Role Conflict-Ambiguity	579	53.0	405	37.1	99	9.0	8	0.7	1091	100.0

generally favourable evaluation of the skills of the supervisors, however, was indicated by the high degree of job satisfaction regarding supervision that was expressed by the respondents.

Also reflective of the positive organizational climates of the organizations was the medium to high degrees of total job satisfaction expressed by the respondents. Most elements of job satisfaction tended to be highly rated as well. However, the wages or salaries respondents received, and especially promotional opportunities, were not as favorably evaluated. Clearly, the blocked mobility patterns that have been described as characteristic of hospitals in the literature, were also present in the project hospitals. It would appear that the hospitals in the sample tended to be high on normative elements that ensured the compliance of its participants, but did less well on the utilitarian aspects. Etzioni's characterization of acute care hospitals as normative rather than utilitarian appears to have some basis in the data provided here.[1]

Not only did hospital personnel express a high degree of job satisfaction with the working relations they had with their colleagues, but they also indicated a high evaluation of the interpersonal relationships within their respective departments. While intra-departmental coordination tended to be rated quite favorably, the extent of role conflict and ambiguity was more likely to be rated as medium or low. Nevertheless, more respondents tended to experience role strain in the form of role conflict rather than role ambiguity.

Table 27 reports the data for bureaucracy and negotiation across hospitals. At least three quarters of all respondents reported bureaucratic authority as being relatively unstructured in a formal sense. This is also true of the data in Table 27 regarding the division of labour, which most respondents perceived as being low. Most structural measures, for example the number of departments, or the number and types of occupations, would place hospitals in a high category relative to other organizations in the degree of the division of labour they exhibit. The uniformly low perception by hospital respondents regarding the division of labour, is in marked contrast to any "objective" measure that could be applied. These are rather surprising findings in view of the relatively rigid status systems reported by most researchers.[2] The results reported here are, therefore, somewhat confusing at first sight.

The fact that a low hierarchy of authority and low division of labour is perceived to exist, may be a function of the high intra-departmental relations and supervisory human relations reported earlier. More importantly, an intensive technology and high interdependency of tasks, while increasing role conflict by increasing the number of contradictory demands hospital respondents experience,[3] may reduce the importance to personnel of objective differences among occupations, under conditions of high interdependency. In addition, most hospital personnel now are being trained in the ideology of "team" approaches to health care which emphasize unity and deemphasize differences among occupational groups.

TABLE 27
FREQUENCY AND PERCENTAGE DISTRIBUTION OF BUREAUCRATIC AND NEGOTIATION FACTORS ACROSS HOSPITALS

Organizational Variable	Low		High		Undecided		Total	
	N	%	N	%	N	%	N	%
A: Bureaucracy								
Hierarchy of Authority	863	79.3	214	19.6	11	1.0	1088	100.0
Division of Labour	889	81.5	186	17.0	15	1.3	1090	100.0
Rules	389	36.0	689	63.7	2	0.1	1080	100.0
Procedural Specifications	712	68.4	324	31.1	4	0.3	1040	100.0
Impersonality	881	80.8	177	16.2	32	2.9	1090	100.0
Technical Competency	465	42.6	612	56.1	13	1.1	1090	100.0
B: Negotiation								
Agreements	425	39.4	652	60.4	1	0.1	1078	100.0
Rules	820	75.8	245	22.6	16	1.4	1081	100.0
Committee	551	50.6	355	32.6	181	16.6	1087	100.0
Task	818	74.6	251	23.0	22	2.0	1091	100.0
Inter-departmental	474	44.7	579	54.6	7	0.6	1060	100.0

Furthermore, the respondents were asked to evaluate their own department. Given the relatively positive evaluation of most of the hospital variables, it may be that a halo effect is operative.

In contrast with the low ranking on the previous two dimensions, the bureaucratic element of rules for encumbents was generally rated as high. In all hospitals there was clear evidence of this particular organizational trait. Nearly all the nursing directors referred to the existence of nursing manuals which included hospital policy and rules. Administrators also included in their "map" of the organization, the expectation and awareness of the existence of rules and regulations.[4] This perceptual set regarding rules, and the manner by which rules are generated, will be discussed later in Chapter VI in the discussion of administrative processes.

Table 27 also indicates that procedural specifications tended to be rated low by the respondents of all the hospitals. Less than a third of the respondents rated their hospitals high on this bureaucratic dimension. While bureaucratic rules were rated high, procedural specifications were rated low. This suggests that the rules establish boundaries on the discretionary powers of the personnel regarding the procedures to be used in performing their tasks. For example, the nursing director of Southern Municipal, in describing the induction process for new employees, stated that:

> "We have job descriptions and when they come in we give them a manual which specifies rules and regulations. They are useful when hired, but later tend to be ignored. Revision of the manuals are done by the groups involved.

> Of course, legal rules, such as consent forms, are givens for all personnel. Guidelines are also available but do not commit personnel to some techniques. We have people who come in from different hospitals where things are done differently. We expect them to conform when a technique is absolutely not acceptable."

In this regard, Bell has indicated that discretion was higher for personnel in the technical than service sectors of the hospitals he studied.[5]

Impersonality was rated as low in all the hospitals. The high emphasis that appeared to be placed on human relations may help to explain this finding.

In contrast, the demand for technical competency as a bureaucratic trait tended to be rated relatively high. Again, this bureaucratic trait may be a consequence of the type of technology employed. An intensive technology creates demands for qualified and often specialized personnel.

Hospitals, therefore, appear to be both bureaucratic and non-bureaucratic on different dimensions.

Most hospital personnel indicated that the type of negotiative behavior which results in the development of tacit agreements tended to occur quite frequently (Table 27). However, negotiation over rules and tasks (e.g. who does what), did not appear to occur to any great extent in the hospitals. Less than a quarter of the respondents rated their hospitals high on these two types of negotiation.

Interdepartmental negotiation was more likely to be rated high than low by hospital personnel. Despite this trend, however, a number of respondents did not feel that this type of negotiation occurred very frequently. Similarly, while half of the respondents indicated that little or no negotiation in committees occurred, one third did indicate a high degree of such behavior.

As with bureaucracy, acute care hospitals exhibit different types and degrees of negotiation. Nevertheless, it would appear from the data presented above that the degree of bureaucracy appears to be low in these acute care institutions, while negotiation as accommodative behavior tends towards medium to high degrees.

II. SOME INTERRELATIONSHIPS AMONG THE ORGANIZATIONAL VARIABLES

The data presented to this point have indicated that the hospitals, in general, have positive organizational climates. Furthermore, these hospital organizations may be described as both normative and participative. In what follows, an attempt will be made to obtain some further understanding of the interrelationships among the organizational variables discussed above, by intercorrelating certain selected independent variables (i.e. professionalism, supervisory skills, decision-making modes, inter-personal relations and intra-departmental relations) with the remaining organizational variables.

Table 28 summarizes the Dxy correlations between professionalism and the selected organizational variables. It is evident, from Table 28, that professionalism is not associated with most of the organizational variables. Pro-

TABLE 28
DXY CORRELATIONS BETWEEN THE DEGREE OF PROFESSIONALISM AND SELECTED ORGANIZATIONAL SKILLS

Supervisory Skills	Dxy
Committee decision-making	.16
Inter-personal decision-making	.15
Total job satisfaction	.07
Technical skills	-.05
Human relations	.04
Administrative skills	-.02
Intra-departmental coordination	-.02
Intra-departmental relations	.13
Role conflict	.02
Role ambiguity	.06
Role conflict/Role ambiguity	.07
Organizational position	.53

fessionalism does have a small positive relationship, however, with both the formal and informal modes of decision-making, as well as with intra-departmental relations. Participation in departmental decision-making, either in committees or in the informal interpersonal networks, is likely to be somewhat greater for professionals in the organization. Professionals are also more likely to evaluate intra-departmental relations more positively than non-professional personnel.

An attempt was made to control for both hospital and departmental contexts. The results were random and inconsistent among hospitals and across departments. It became evident from this analysis that the lack of association obtained at the more general levels of analysis, was partly due to the inter-hospital, inter-departmental differences which tended to suppress the associations.[6] It would appear that specific hospital and department related factors created different situational contexts for professionals and non-professionals in the sample.

In summary, while professionalism is widely regarded as having significant and consistent effects on hospital organizations, the data presented here do not bear this assumption out. The data suggest, instead, that the associations between professionalism and the organizational factors are dependent on hospital and department related constraints. In this regard, administrators would be unwise to count on specific and consistent effects of professionalism on organizational behavior and functioning without also taking into account situational constraints. Professionalism appears to function as an intervening variable, having either a negative or positive effect depending on other contextual factors.

In much of the literature on organizations, leadership and supervisory styles are considered important factors. They affect such organizationally related factors as job satisfaction, productivity, labour turnover, and communication patterns.

As indicated earlier, most hospital respondents rated their supervisors favorably on all supervisory skills. However, they were slightly more critical about their supervisors' administrative skills than either the technical or human relations skills exhibited by their supervisors.

Tables 29-31 summarize the associations between the three supervisory skills and the selected organizational factors for all hospitals. The findings of Mann,[7] and Georgopoulous and Mann,[8] that supervisory skills have an important and pervasive effect on organizational behavior, appears to be supported by the data collected for this study.

The Dxy correlations reported in Table 29 indicate that the higher the supervisors' technical skills, the greater the participation in formal committee decision-making. This is also true for informal, interpersonal decision-making. There is a moderately strong positive relationship between supervisors' technical skills and total job satisfaction.

While intra-departmental coordination and relations increase with increasing technical skills of the supervisors, the association with role conflict and ambiguity is negative. That is, the more favorably supervisors are evaluated as technically expert, the less likely staff are to experience role

TABLE 29

DXY CORRELATIONS BETWEEN SUPERVISORS' TECHNICAL SKILLS AND SELECTED ORGANIZATIONAL FACTORS

Supervisory Skills	DXY
Committee decision-making	.15
Inter-personal decision-making	.19
Total job satisfaction	.29
Intra-departmental coordination	.19
Intra-departmental relations	.16
Role conflict	-.15
Role Ambiguity	-.25
RC-RA	-.25
Professionalism	-.05

RC-RA = Role Conflict/Role Ambiguity

TABLE 30
DXY CORRELATIONS BETWEEN SUPERVISORS' HUMAN RELATIONS SKILLS AND SELECTED ORGANIZATIONAL FACTORS

Supervisory Skills	DXY
Committee decision-making	.23
Inter-personal decision-making	.28
Total job satisfaction	.46
Intra-departmental coordination	.28
Intra-departmental relations	.27
Role conflict	-.27
Role ambiguity	-.34
RC-RA	-.35
Professionalism	.04

RC-RA = Role Conflict/Role Ambiguity

TABLE 31
DXY CORRELATIONS BETWEEN SUPERVISORS' ADMINISTRATIVE SKILLS AND SELECTED ORGANIZATIONAL FACTORS

Supervisory Skills	DXY
Committee decision-making	.05
Inter-personal decision-making	.11
Total job satisfaction	.25
Intra-departmental coordination	.62
Intra-departmental relations	.31
Role conflict	-.34
Role ambiguity	-.30
RC-RA	-.36
Professionalism	-.02

RC-RA = Role Conflict/Role Ambiguity

conflict, and in particular role ambiguity, and the combined effects of role conflict and ambiguity.

As can be seen from Table 31, the effect of administrative skills on the organization factors is also similar to that of the technical and human relations skills. While supervisors' administrative skills are only slightly related to the two decision-making modes, they are more strongly related to intra-departmental relations, and role conflict and ambiguity, than are the other two types of supervisory skills. The very strong positive relationship with intra-departmental coordination is especially apparent. In contrast, human relations have a noticeably strong positive effect on job satisfaction, as shown in Table 30. It would appear that the different supervisory skills have certain selective influences. Human relations skills appear to be more influential in interpersonal and attitudinal states, while administrative skills are more effective in structural areas.

Jules Henry has argued that decision-making can occur through two major pathways in an organization.[9] A hierarchical or "pine-tree" pattern can occur, whereby decisions are made by a person holding high organizational position. These decisions are then relayed to role encumbents lower in the organizational hierarchy, who are expected to comply with the directives. A second pattern that Henry identified is the "oak tree" pattern, or what others have called the collegial pattern. In this pattern decisions are made at the horizontal as opposed to the vertical levels of the organization. It is also possible that decisions made according to the oak tree pattern can be made in formal arenas or in the informal networks. Brinkerhoff has shown that decision-making in formal arenas in the industrial organizations which he studied, did not reduce the amount of decision-making that occured in the informal channels.[10] Finally, it has been argued that decision-making in professional organizations occurs in informal and not formal channels.

As Tables 1 and 2 in Appendix A indicate, both types of decision-making occur in the hospitals. Inter-personal decision-making is somewhat more likely to occur than committee decision-making. Nevertheless, the greater the participation in formal decision-making, the more likely respondents are to engage in informal interpersonal modes of decision-making. However, intra-departmental committee decision-making is not associated with coordination, role conflict or role ambiguity.

It can also be seen from the Dxy associations in Table 32, that the better intra-departmental relations are, the more likely organizational members are to participate in committee decision-making. This is contrary to what is generally held to be good "management ideology," since most organizational theorists argue that involvement comes before good interpersonal relations.

As shown in Table 33, there is no apparent relationship between informal decision-making and coordination. As with committee decision-making, however, intra-departmental relations have a much stronger and more direct association with interpersonal decision-making than vice versa. Good

TABLE 32
DXY CORRELATIONS BETWEEN INTRA-DEPARTMENTAL COMMITTEE DECISION-MAKING AND SELECTED ORGANIZATIONAL FACTORS

Supervisory Skills	DXY
Inter-personal decision-making	.31
Intra-departmental coordination	.02
Intra-departmental relations	.07
	(.14)*
Role conflict	-.05
Role ambiguity	-.07
RC-RA	-.09

*Figures in brackets ( ) indicate a DYX correlation.
RC-RA = Role Conflict/Role Ambiguity

intra-departmental relations, apparently, are a fairly important factor in improving participation in the hospital's decision-making apparatus, whether this is through formally established committees, or occurs spontaneously in the social networks. While informal decision-making is not associated with role conflict or role ambiguity (Table 33), intra-departmental relations are strongly and positively related to intra-departmental coordination, and negatively associated with role conflict and role ambiguity (Table 34).

Table 35 indicates that intra-departmental coordination also has a strong negative association with role strain. In addition, the higher the coordination, the greater the total job satisfaction of the respondent.

However, good intra-departmental relations and coordination do not happen by chance. As was indicated above, these are conditions that are associated with the type of supervisory skills employed. Figure 2 attempts to summarize the pattern of relationships that have been shown to exist in this chapter. Figure 2 clearly portrays the significance of these patterns, by tracing the relationships that do exist. It is clear that supervisory skills assume a major role in defining the organizational climates and structures of the project hospitals. But it is also clear that the pattern of relationships are complex, involving a number of indirect linkages between the variables themselves.

As indicated earlier, the skills of supervisors tend to be very important, since technical, administrative and human relations skills are positively and directly related

TABLE 33
DXY CORRELATIONS BETWEEN INTER-PERSONAL DECISION-MAKING AND SELECTED ORGANIZATIONAL FACTORS

Supervisory Skills	DXY
Intra-departmental coordination	.06
Intra-departmental relations	.16
Role conflict	(.28)*
Role ambiguity	-.05
RC-RA	-.07
	-.08

*Figures in brackets ( ) indicates a DYX correlation.
RC-RA = Role Conflict/Role Ambiguity

TABLE 34
DXY CORRELATIONS BETWEEN INTRA-DEPARTMENTAL RELATIONS AND SELECTED ORGANIZATIONAL FACTORS

Supervisory Skills	DXY
Intra-departmental coordination	.32
Role conflict	-.21
Role ambiguity	-.31
RC-RA	-.31

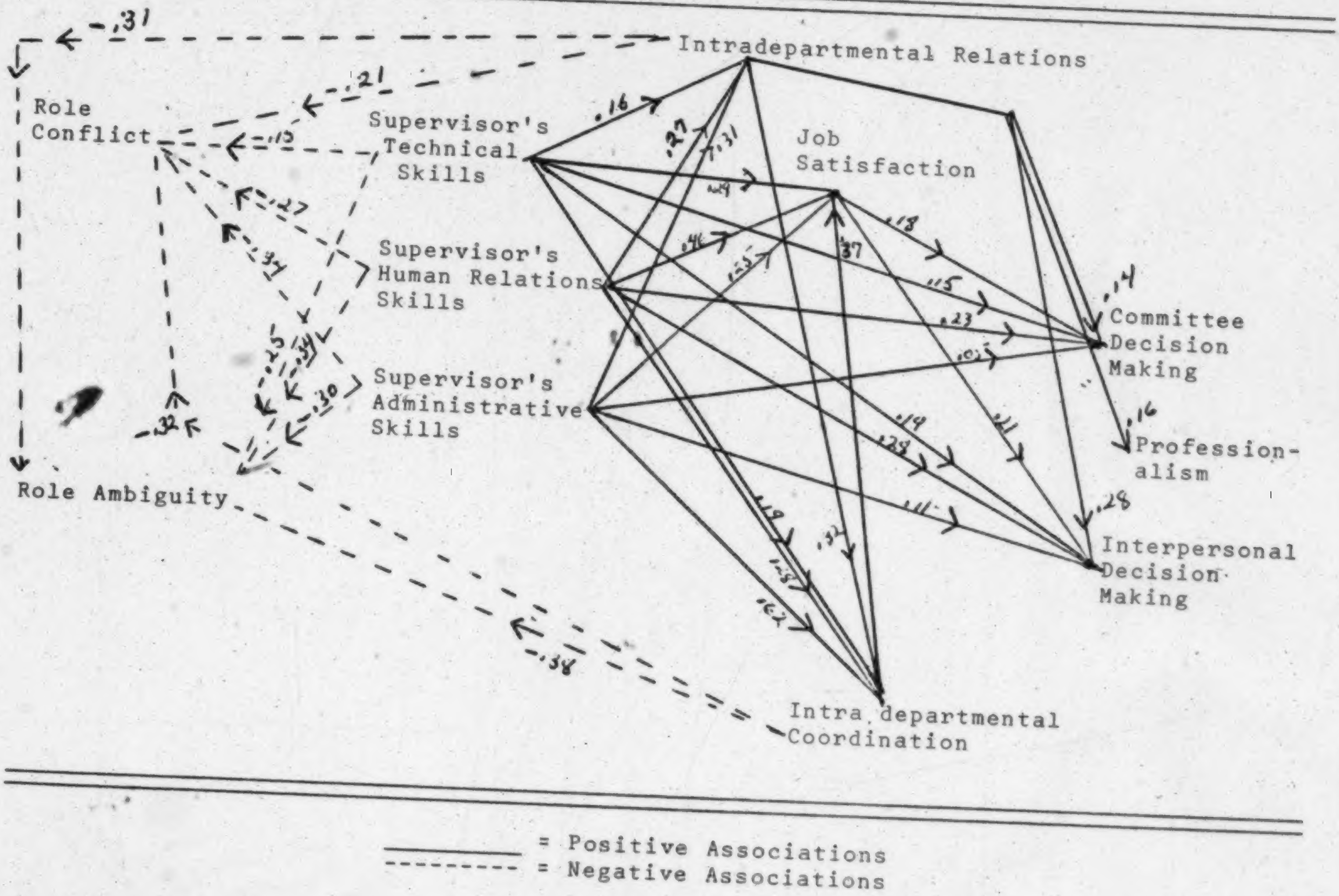
RC-RA = Role Conflict/Role Ambiguity

TABLE 35
DXY CORRELATIONS BETWEEN INTRA-DEPARTMENTAL COORDINATION AND SELECTED ORGANIZATIONAL FACTORS

Supervisory Skills	DXY
Total job satisfaction	.37
Role conflict	-.38
Role ambiguity	-.35
RC-RA	-.31

RC-RA = Role Conflict/Role Ambiguity

FIGURE TWO
CORRELATIONS AMONG THE SELECTED ORGANIZATIONAL VARIABLES


Intradepartmental Relations
Role Conflict
Supervisor's Technical Skills
Job Satisfaction
Supervisor's Human Relations Skills
Supervisor's Administrative Skills
Committee Decision Making
Professionalism
Interpersonal Decision Making
Role Ambiguity
Intradepartmental Coordination
-.31
-.21
-.12
-.27
-.34
-.30
-.32
-.38
.16
.27
.31
.29
.46
.25
.37
.18
.15
.23
.25
.14
.16
.14
.28
.21
.11
.28
.19
.32
.28
.62
= Positive Associations
= Negative Associations

would reduce bureaucratic impersonality.

A further factor reducing the hierarchy of authority, as well as the division of labour, is the form of technology employed by the organization. The hospital has been described as employing an intensive technology. An intensive technology is based on a task structure in which tasks are interdependent and mutual adjustment is employed as a form of coordination. The emphasis on the "team approach to patient care" exemplifies this technological situation. In such situations, while there may be many specialized and complex tasks to perform, interdependency of tasks may reduce, perceptually, the differences among specialized task structures.

Blau and Scott have referred to a number of organizational paradoxes.[12] The data reported here suggest an addition to their list of paradoxes. That is, increasing the complexity of an organization's technology also tends to increase the objective degree of the division of labour.[13] However, the increasing complexity and structural differentiation also tends to increase the need for integration, as well as increasing the interdependency of tasks.[14] Indeed, most of the administrators and nursing directors reported instances where changes in the functioning of one department or group of workers quickly caused disruptions in other departments or work groups. The systemic nature (i.e. linkages between tasks and task groups) of organizations is apparently quite high in the sociotechnical sector of the hospital organization. Whether it is higher or lower than that of other comparable organizations would be an important area for comparative research in organizations.

High interdependency of tasks, therefore, may perceptually reduce the division of labour among respondents, resulting in the low scores obtained in this study. Thus, *objective task differences among organizational members become less salient the more performance of work depends on the participation of others*.

In this regard, Thompson has pointed out that high interdependency of tasks increases coordination by mutual adjustment.[15] As indicated earlier, most of the respondents (74.5%) reported medium to high degrees of involvement in interpersonal decision-making. At the same time, however, mutual adjustment appears more likely to occur in some areas than in others. Specifically, tacit or agreements negotiation tends to be high. This is also true with respect to interdepartmental negotiation, and suggests that the interfaces between departments and different task structures are critical areas demanding mutual adjustment.[16] Rule, committee and task negotiation were reported to be low. As Friedson has cogently pointed out, however, negotiation over tasks and rules will occur in situations where no "...efficacious method of "curing" the mentally ill exists."[17] The technology employed in the acute care institution, in contrast to that employed in the treatment of mental illness, is a more

> ...stable and frequently standardized therapeutic technology (which) sets distinct limits on the degree of negotiation that can take place among the staff without interfering with the functional goals of the organization... good human relations must not mislead one into believing that members of the team are negotiating without limits.

> The task, the prerogatives of its practitioners, the equipment available to accomplish it, and administrative precedents all limit and constrain the behavior of the workers.[18]

Thus, low task negotiation in the hospitals may be explained by the fact that tasks are given, although interdependent. Thus, while tasks are non-negotiable (i.e. who does what, and what to do), low procedural specifications but high bureaucratic rules (which act to constrain the behavior and discretion of workers and their decisions about which procedures to use), create a situation where informal or tacit agreements occur around a task structure that is developed, complex, and interdependent.

At the same time, interdependency of tasks reduces authority distinctions in organizations employing advanced forms of technology.[19] Furthermore, tasks at the socitechnical level of the organization tend to be structured, thereby permitting the reduction of hierarchical distinctions. Finally, bureaucratic rules tend to be high, which also acts to reduce hierarchical distinctions in authority, by reducing the strain involved when supervision instead of rules is used as a means of control. This in turn would support high human relations skills and a high organizational climate.

Except for the negative association between the bureaucratic division of labour and committee negotiation, increasing degrees of bureaucracy in the remaining bureaucratic dimensions increased negotiatory behavior.

It would appear, then, that in organizations like acute care hospitals, which employ an intensive form of technology, that the organization's bureaucracy stimulates and supports negotiatory behavior. In turn, however, negotiatory behavior through both formal and informal channels makes it possible for the bureaucracy to function. This situation also appears to create the conditions necessary for the positive organizational climates found in this study. The patterns established in Figure 1 provide the basis for those identified in Figure 2. On the other hand, these latter patterns, in turn, would also help maintain those in Figure 1 and so establish a normative, participative organizational climate based upon the functionally reciprocal relationship between bureaucracy and negotiation.

III. SPECIFIC SITUATIONAL AND ORGANIZATIONAL CONTEXTS

So far, this chapter has been mainly concerned with the identification and typification of organizational climates, and the correlations among the organizational variables. The identification of a general pattern, although based on a limited intercorrelational analysis, establishes the groundwork for a discussion of the administrative processes in these hospital organizations in Chapter VI. The objective of both of these analyses are and will be to establish general patterns, both with respect to organizational structures and administrative processes, as well as to establish the relationship between these two aspects of the study.

While the identification of general patterns is the first objective of a "generalizing science" such as sociology, the analysis of specific cases also serves to highlight and expand general patterns. That is to say, the analysis of specific situational contexts may provide insights into contingent conditions affecting the general patterns. In this section of the chapter, profiles of each of the hospitals will be developed and discussed in relation to each of the administrators. The question essentially addressed is: "How does the specific organizational context influence the behavior of the administrator of that particular organization?"

While some recent writers on the administrator's role have indicated that hospital administrators are increasingly acquiring an "external orientation," recognition must also be given to the historical and growing concerns the administrator has with the "internal" operation of the organization.[20] These two seemingly opposing orientations, however, are interrelated.

The hospital has increasingly acquired the function of a health centre for the community.[21] This has forced the administrator to focus his attention on coordinating the hospital with external agencies. At the same time, however, the administrator has also found that external advances in the technology of medical care have increased the organizational complexity of the hospital. This has tended to force the administrator out of a restricted business or accounting role, into one involving a legal responsibility for the quality of health care provided in the organization, as well as for the coordination of health care activities in the organization.[22]

On the other hand, an expanded role within the organization has forced the administrator to deal with stimuli emanating from the external environment. This has occurred because these external stimuli affect his coordinative functions within the organization. While the relationship between the two orientations is symmetrical, and therefore does not permit a cause-effect relationship to be easily sorted out - if at all - it would still appear to be useful to depict the organizational context with which the administrator must cope. For this reason, data relevant to this concern was collected and will be presented in the hope of illuminating the complex role of the hospital administrator.

Urban Hospital

The structure of administration in Urban Hospital was such that the administrator was in less direct contact with departmental functioning than were the administrators of other hospitals. The delegation of tasks and authority to administrative officers was the most extensive of all the hospitals, and clearly integral to the organization of this administrator's role. Indeed, in emphasizing the differences in degrees of control in the internal as compared to the external organization, this administrator stated that:

> "Delegation is a mechanism of control over the organization. I get feedback or reports from my officers and from the various committee meetings in order to find out what is going on, to ensure that the job was done, and if it was done correctly."

In a similar manner, and in an attempt to describe his role vis-a-vis the other administrative roles in the organization, this administrator indicated that:

> "The function of the board is to determine the purpose and goals of the organization and set broad policies. It

> is my task to implement these policies and check on their implementation. This is done by delegating task areas to my administrative staff and to committees, and by obtaining feedback in the form of reports. With my administrative officers and the committees, I determine policy recommendations which are sent back to the board for review. This determination of policy is done in conjunction with department heads or directors. It is the directors' responsibilities to fill in the policies by setting up procedures in line with policies."

One of the implications of the delegation process was that the administrative officers were directly responsible for certain task areas and that the administrator should not intrude into these delegated task areas. In return, however, the administrative officer was expected to make sure that "No person must accept someone from the outside without telling me, and if they have something to say I'd better know about it." In return for this control over by-pass, there was the expectation that the administrator would not impinge on the delegated areas. Instances were related where personnel had sought the help of the administrator without first going to the administrative officer in charge of that area. The referral back to the administrative officer in charge of an area even occurred with medical staff and the medical director.

Despite the efforts and expectations not to interfere, however, the nursing director expressed some dissatisfaction with the administrator's exercise of authority in what she considered to be her area of action. While she recognized that nursing personnel costs amounted to 53% of the budget, and that this might explain his continual reading of the nursing reports and the many subsequent questions he directed to her, she expressed a desire for "...more autonomy like the other professions." Indeed, most of the nursing director's dissatisfaction seemed to revolve around a comparison with other professional groups, such as the physicians, and what she thought to be their relatively greater amount of freedom from administrative control.[23] At the same time, the nursing director recognized that the administrator had experience in hospitals at the lower ranks in nursing care departments, earlier in his career, and attributed part of his interests and impingement to this earlier experience.

Despite this conflict, however, the administrator did delegate areas of responsibility quite extensively. A consequence of this broad delegation of task areas, was that it removed the administrator from direct involvement in departmental functioning, while making his role appear like that of a "trouble-shooter."

Two points bear mentioning in this regard: first, the effect of size, complexity and specialization of the organization on the administrator's role: and second, the resultant structure of administration and breadth of the administrator's role.

The size of the organization, and in particular, the complexity and number of specializations and departments within the organization, made it impossible for the administrator to retain direct control over all areas. As will be shown later, the reorganization of the administrative structures in the smaller hospitals also reflected these influences on the administrators roles. In short, the complexity of the organizational structure, and the increasing sophistication in the technology, had forced the administrator to delegate task areas while assuming a broader integrative function. As one of the administrator's assistants put it:

> "He would be the first to admit that he couldn't do his job without us. But we're in the same position. He acts as a resource person. He very seldom personally becomes directly involved in my area of work. But I can talk to him and get his help in interpreting policy. I can count on him. After all, he's got thirty years of experience in handling people."

The structure of administration does not just refer to the delegation of task areas to assistants, but refers as well to the fact that the administrator's role had developed in this organization into one which is broadly integrative. The role was enacted, partly, through delegating and maintaining feedback, but also by providing direction and advice to each of his officers individually and collectively in committees. In essence, the administrator was forced to move through a broad range of problem areas in an attempt to maintain an overall "...picture of the organization," and in order to integrate the separate efforts of his administrative officers. He did this by establishing committees "...to mediate differences" among persons responsible for different areas. He also acted as a central information source or node through which problem areas requiring coordination could be identified, and through whom board policy could be interpreted.

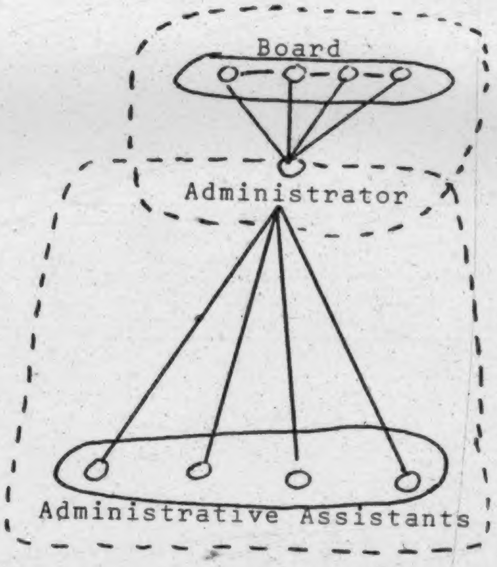
The general characteristics and consequences of this type of structure have been discussed in Chapter II. Unlike the star structure of the laboratory experiment, however, not all members are organizationally homogeneous. That is to say, the policy making body (the board) and the implementation body (the administrative assistants) are mediated through the role of the administrator. Through this role, policy statements of the board are interpreted, directions provided, problem areas identified, and coordination of the separate efforts of the administrative officers achieved, both through personal effort and by ensuring that formal integrative and conflict resolution mechanisms exist.

Figure 3 attempts to depict this structure.

The breadth of the role was clearly illustrated in two ways. First, in response to the interviewer's attempts to clarify the general purpose of the project, this administrator literally reviewed his desk and daily log. The resulting list of activities was too long to duplicate here, but included such diverse areas as medical research and requests for bed space, contact with other hospitals and hospital councils, requests for leaves of absence, planning a program to honor long service personnel, organizing monthly meetings and agendas, a drug variance study, surveillance of hospital growth patterns, maintenance of a list of equipment and costs in order to control requests for funds, and the maintenance of a record of bed use per physician to counter physician complaints about his interfering in the physicians' use of hospital facilities.

This diversity in interests and activities reflects the breadth of the role and creates the impression that it is only a "trouble shooter" role. It should be kept in mind, however, that these problems are resolved in the context of

FIGURE THREE
ADMINISTRATIVE STRUCTURE



Policy Making

Integrator, interpreter,
Problem definer

Policy implementing

general objectives, while at the same time influencing the direction which general objectives may take. For example, the issue of abortion created problems of bed space and raised the question of providing a service demanded by society, while being of little value to the nursing education program. The question of establishing an abortion clinic, while referred to a committee to develop policy recommendations, highlighted the problem in decision-making which occurs when objectives of an organization conflict - in this case, the service function and the education function of the organization.

It is no wonder, then, that Management By Objectives[24] becomes an appealing management tool, since it helps resolve the problems inherent in making decisions about conflict issues. It is a means of "rationalizing" decision-making.

While such management techniques may be useful in the rationalization of such processes. Urban administrator's objection to M.B.O. partly reflected his personal philosophy that the hospital was "...an organ of society and must serve its changing needs." Rationalization of organizational objectives may stand in the way of changing services to meet the demands made on the organization. Nevertheless, the administrator emphasized the need to make "...positive decisions and live with them" within the context of general policy set by the board. This policy, however, appeared to be open to change, depending on the recommendations made to the board by the administrator and his assistants.

The breadth of the role, and the false impression that it is merely a "trouble shooter" role, was also attested to by the numerous telephone calls and the variety of problems about which the administrator was called upon to make decisions. 25

In some cases a problem was referred back to a department head or executive assistant. In others, the administrator made a decision. In one case, for example, a nurse had asked for advice about certain patient care activities that the nursing staff wished to engage in, but which the medical staff resisted. In relating the incident, this administrator indicated that he had agreed that the nurse take action in a specific case, providing she inform the medical officer in charge and report back to the administrator the following day. These kinds of negotiated agreements occurred frequently in all the interviews with the administrators.

One final point bears discussing before describing the socio-technical context of the organization. That is, that the role enacted by this administrator, in part due to the extensive delegation, was more externally oriented than those of the other administrators in the sample. Unlike the other administrators, this administrator related a large number of issues which referred to external factors. These included the abortion issue mentioned above, as well as other problems about government policy regarding nursing education, medical staff as autonomous practitioners, medical education, programs and services offered including outpatient services and the operation of day care clinics, regionalization, inter-hospital relationships, and community-hospital programs and interagency relationships. In all instances, the administrator saw his role as one in which he had to:

> "...deal with these areas of ambiguity. If I didn't, none of our programs would operate. We'd be changing rules everyday. I've got to decide when we should make changes. I am responsible for this because the board holds me responsible for the execution of their policies in my mileau - this organization."

If the role of Urban administrator was broad, and inclusive of both externally and internally related organizational factors, his administrative behavior in the organization was predicated on certain assumptions and concerns.

One of these concerns related to the size of the organization and the need to prevent dehumanization. Explicit in this concern was the need to involve his staff and personnel. In addition, it was felt that this involvement began with top management.

> "You have to work from the top down to the task level. (You) can't have an effective organization without everyone participating. As size of the organization grows this is necessary to prevent dehumanization."

It is evident from Table 1 in Appendix A, that over two thirds of the personnel indicated medium to high involvement in decision-making. Within departments nearly three quarters of the personnel also indicated medium to high degrees of involvement in interpersonal decision-making (Table 2, Appendix A).

The emphasis that management "...sets the tone of the organization," was perhaps best reflected in the personnel's evaluation of their supervisors and the degree of job satisfaction they expressed about the supervision they received. Like most of the respondents in the other hospitals, Urban Hospital's personnel had a favorable evaluation of their supervisors' technical skills (Table 3, Appendix A).

More pertinent to the influence of administrative style on the climate within the organization, was the relatively favorable evaluation of supervisors' human relations skills. As is evident in Table 7, Appendix A, however, proportionately fewer of the respondents in Urban hospital rated their supervisors high on this dimension as compared to the other institutions. Midland Municipal and Southern Religious hospitals were more similar and favorable in this regard, whereas Urban and Southern Municipal were more similar.

Urban administrator's concern about management practices may help explain the reasonably favorable evaluation of supervisors on a number of aspects regarding their human relations skills. His concern with the type of supervision, and with reducing the dehumanizing effect of large size and technology, included submitting himself to questioning by department heads and supervisors at management meetings in order to:

> "...get an insight into how these people see things and what kinds of problems they call problems. Things I don't think are problems sometimes are - to these people. I always learn something new from these people."

His concern was also manifested in what might be called his "hall-walking" behavior. In an effort to make himself available to people, he would quite often deliberately spend some time in different sections of the hospital in order to "...create opportunities for dialoguing."

Despite these efforts, however, fewer respondents in Urban hospital rated their supervisors high on aspects related to human relations skills, at least as compared with the smaller hospitals. Respondents felt less able to get help and support from their supervisors, less able to discuss their job, less likely to have their work appreciated by the supervisors, and in particular, less likely to feel that supervisors sought their ideas and opinions, or gave them support (Tables 8-12, Appendix A). The concern of Urban administrator regarding supervision and dehumanization appeared to be justified, and his efforts to reduce this reflected a reasonably accurate perception of his organization's climate.

Perhaps because of the size and complexity of the organization, and the greater difficulty in administering departments, supervisors were consistently rated lower on administrative skills (Tables 13-16, Appendix A) than in the smaller hospitals. This was also indicated by the fact that proportionately fewer of the respondents in Urban hospital rated intra-departmental coordination as high (Table 24, Appendix A).

The difficulty in maintaining a positive organizational climate in a large organization was illustrated by the lower degree of total job satisfaction expressed by respondents in Urban hospital. Indeed, 21% fewer respondents reported high job satisfaction as compared with Southern Religious. On the other hand, both Urban and Southern Municipal were more similar to each other in this regard, and different from Midland and Southern Religious which were more alike. This difficulty was also apparent in comparing the extent of job satisfaction that Urban hospital respondents expressed with regard to working conditions and opportunities to make work decisions.

Dissatisfaction with promotional opportunities and blocked mobility patterns was evident in all hospitals, and especially in Urban Hospital. Dissatisfaction with wages or salaries was especially apparent in the two northern hospitals, including Urban. More intense and active unions, and more active labour markets, may have contributed to these two sources of job dissatisfaction. Both Southern Municipal and Southern Religious were more isolated in this regard. The opportunities to compare salaries and promotion opportunities were also greater in the northern than southern areas.

Finally, the greater difficulty in establishing a positive organizational climate in a large organization was partly reflected in the lower evaluation of intra-departmental relations, as well as in the greater amounts of reported role conflict (Tables 25-34, Appendix A). Role ambiguity appeared to be less of a problem (Tables 35-42, Appendix A).

The large organization was more structured in terms of bureaucratic authority than were the smaller hospitals. Indeed, Urban Hospital tended to exhibit more bureaucracy on all factors (Table 43-48, Appendix A). While there was a tendency to be somewhat more bureaucratic, it was also true that, like the other organizations, Urban exhibited a low degree of bureaucracy with respect to bureaucratic authority, the division of labour, procedural specifications and impersonality (Tables 43, 44,46,47, Appendix A).

If Urban was slightly more bureaucratic, it also exhibited more negotiative behavior than the other hospitals. At the same time, however, negotiation over rules, tasks and in committees occurred less frequently than interdepartmental, and agreements or tacit negotiation (Tables 49-53, Appendix A).

In summary, much of the administrative process and behavior of the administrator of Urban hospital was organized around the delegation of task areas to assistants, and the subsequent efforts to coordinate the efforts of his assistants. At the same time, the external environment appeared to be influential in directing the administrator into a position through which he attempted to buffer his organization from a potentially disruptive external environment which might best be described as heterogenous and fluctuating. This situation fostered a feeling of a "...lack of control over what happens outside the hospital..." On the other hand, the delegation of task areas, the review of reports and information from committees and executive officers, plus the relatively positive organizational climate, fostered feelings of control over the internal "mileau" of the administrator. Despite this, the administrator's continuing concern about the development of a favorable organizational climate in a large hospital, and his subsequent efforts to reduce the feelings of "dehumanization," appeared to be justified according to the data obtained from the respondents regarding the social structure of the organization.

Midland Municipal Hospital

This hospital and its administrative staff were unique in a number of ways. While the administrator of Urban most clearly enacted a generalist-integrative role, the administrator of

Midland directed much of his role activity towards the medical staff. While the medical staff was a reference group to Urban administrator, as well as to the other administrators, it was most critical to the organization of the role of the administrator of Midland.

The assistant administrator of Midland indicated this when he stated that:

> "He (the administrator) works very closely with the medical staff. There is no medical director, therefore it's necessary for him to do this. They (the medical staff) view his recommendations very highly and the medical staff will listen to him. Most of the time they take his advice.... They may not, of course."

The administrator himself indicated that "...I spend a lot of my time with the board and the medical staff." The nursing director also illustrated his concern with the medical staff, while at the same time suggesting some negative aspects of this concern:

> "He is very interested in the medical staff. But he is reluctant to make a decision where the medical staff is concerned and this leads to some wishy-washy decisions sometimes. He is slightly intimidated by the doctors. This is the only area where I feel some frustration. Otherwise he is very supportive of nursing, honest and fair. We have a mutual respect for each other and we're not afraid to complain to each other. He is willing to admit mistakes. I would say that in this case administration is the administrator."

Another point of difference about the structure of administration in Midland was the strength of the nursing director. While all administrators had a close working relationship with their nursing directors, the nursing director in Midland appeared to have a more colleague-like status and greater sphere of power. This may possibly have been due to the administrator's more direct concern with the medical staff, and to the personality and administrative capabilities of the nursing director herself. For example, the nursing director felt that she was "...an equal with the administrator, although I am hierarchically subordinate." Furthermore, she felt she had:

> "...a lot to say about running the hospital, although I know some of my colleagues are in a less advantageous position. The administrator doesn't tell me what to do about my department. Who tells who what the budget is, is important. The role of the administrator is a facilitator to the nursing director and vice versa - each provides back up services."

She also felt that she should be included in the board meetings, and that while she did sit in:

> "...on some meetings, I would like to be included more often. I also think I should be allowed to participate in the J.C.C., but he doesn't think so."

None of the other nursing directors even considered that their role should include involvement in the Joint Conference Committee.

Furthermore, this nursing director was responsible for reorganizing the nursing department some years previously - a change which apparently had become institutionalized at the time of the study. Part of this change involved the removal of supervisors and the use of a clinical nursing specialist. This change had, apparently, caused some conflict with the medical staff. "They didn't like it, but I stuck to my guns."

Despite these strong personalities in the organization, there was an insistence on informal communication and especially on a participative organization. The administrator stated, for example, that:

"We have direct meetings. Most are not routine but

> are rather frequent informal meetings. I see the director of nursing once a day at least....I communicate with my department heads by visiting them in their offices or they come to mine."

> "I use written communication for directives. They're not used very often, mainly because they're not understood by everyone. If its not a simple message, then I explain it as well as I can to make it clearer."

The assistant administrator insisted that:

> "Nursing department committees are used effectively. They're used to accomplish things - they are informal and have specific jobs to do. They make effective use of informal committees."

The nursing director indicated that:

> "Each year we sit down to look at our objectives for the next year. The head nurses and the staff set these objectives for patient care."

In response to a question regarding the use of written documents, she stated that:

> "Policy is written and I send out memorandums for clarification. Mainly we do a lot of verbal communicating. Any problems we have are discussed between myself and the head nurses. Usually we meet for coffee at ten in the morning to discuss things over coffee. I've even invited people from other departments so that we can discuss problems that arise between departments. We invited the maintenance people in because the windows on our Ob and Gyn ward were off and it was hot. The bugs were a real nuisance."

The interviews generally indicated that the administrator and the nursing director felt that the organization was "...person centered." There were areas of concern, especially regarding cost control and budgets:

> "In the area of budgeting, we have to practice what's preached. These budgets are developed by people in cost centers and are reviewed by the management team and then by the board. I really appreciate the nurses' involvement in the cost program and their good response. I question other administrators' claim that the nurses aren't interested."

Much of the administrative action of the management team assumed that their organizational climate was quite favorable.

While Midland ranked fourth in terms of the number of personnel reporting high involvement in committee decision-making, it ranked second in the proportion indicating high involvement in informal interpersonal decision-making (Tables 1-2, Appendix A).

Furthermore, Midland ranked, sometimes second and usually first, in the personnel's evaluation of their supervisors' technical, human relations skills and administrative skills (Tables 3-16, Appendix A). Indeed, in many respects, Midland and Southern Religious were most similar and most positive about their organizations in all aspects. This included the total job satisfaction of the hospital personnel, as well as job satisfaction with the supervision the personnel felt they received.

On the other hand, job satisfaction with promotional opportunities, and especially with wages or salaries, was much lower than the other two medium sized hospitals, but similar to the larger hospital. As suggested previously, this may have been due to a more active labour market, providing these personnel with an opportunity to compare themselves with other groups. Despite these sources of job dissatisfaction, the personnel of Midland expressed the greatest job satisfaction with their working conditions, the opportunities to make work decisions, and finally with the working relations they had with their fellow workers. The data on job satisfaction is reported in Tables 17-23, Appendix A.

Further support for evidence of a positive organizational climate in this organization was reflected in the high evaluation of intra-departmental relations by the respondents. In addition, as compared to the other three hospital organizations, Midland tended to report the least bureaucracy, except for its greater bureaucratic demands for technical competency (Tables 43-48, Appendix A). It was intermediate, however, with respect to negotiation, and shared this rank with Southern Religious (Tables 49-53, Appendix A).

The positive evaluation of supervisory skills, plus the high proportion of personnel reporting high intra-departmental coordination (Table 24, Appendix A), and low role conflict and ambiguity (Tables 26-42, Appendix A), may partly explain the administrator's ability to direct much of his attention to medical staff concerns. There was also a strong nursing director who made maximum use of her committees and a participatory style of management:

> "The nursing committee is made up of people who I work directly with to determine policy, planning, and coordinating. This is the way policy determines policy ...Policy is determined at the head nurse level. You don't need a police force to keep policy obeyed. If they're not followed, usually they're out of date and need to be changed."

This factor might also partially explain the administrator's particular role characteristics. That is to say, a smoothly functioning sociotechnical system may not only enable an administrator to direct his efforts in other directions, but may also be a source of power to his role others who influence these aspects of the socio-technical system. In this case, the colleague-like nursing director/administrator relationship may have been based on this highly favorable and well functioning organization. This systemic aspect of the organization was hinted at by the administrator of the pretest hospital who stated that:

> "The medical staff/administrator relationship depends on the quality of patient care and supportive services."

Southern Municipal Hospital

The disruption of the normal "steady states" of an organization perhaps best illustrates the effect on the administrator's role of the social structure of the socio-technical system.[26] That is, the normal functioning of an organization - including the daily crises that are expected and usually organized for, even though their exact substantive natures are not known - is not necessarily the ideal situation to throw light on such areas of analysis. Organizational crises, like role embarassments, may be useful as research techniques to alert the researcher to patterns that normally exist, but which may be overlooked because they are "taken for granted" - both by the sociologist and the organizational participants.[27] Ethnomethodologists, at least, suggest that these are potential pitfalls in the sociologist's methods. At the same time, however, comparative research can highlight patterns that are common to all situations, while picking out patterns that depend on the "normal, but special" situations, such as was the case with Midland and its administrator.

Southern Municipal and its administrator reflected both these approaches, since in many ways this administrator's role and the structure of administration were similar to that found in the other hospitals. At the same time, however, the organizational crisis which occurred at the time of the study highlighted some differences that may have contributed to the crisis.

Like the other administrators, the administrator of Southern Municipal delegated task areas to his assistants. While the process of delegation was not as extensive as that of Urban administrator, whose organizational task environment was also more extensive, the use of reports and committees as an integrative and control device was evident.

> "I get reports from my department heads. This is feedback or information I use to check on how we stand."

> "We meet regularly (the nursing director, assistant administrator and the business manager) to discuss our operation. The final decisions are mine, however, if an agreement is not made."

Similarly, the nursing director and assistant administrator shared the perspective that committees were arenas in which both information was passed on and problems of coordination were resolved.

> "The head nurses meet once a week and there are numerous committee meetings for different functions. We achieve coordination through department head meetings."

At the same time, however, members of the management group met informally to discuss their problems.

> "His door is always open to me. I quite often discuss the problems I am having with him... He's democratic although sometimes rigid - not often."

A consequence of delegating responsibilities for task areas was the need "not to undermine the heads of the departments." Consequently, problems were referred back to department heads. Similarly, interdepartmental conflict was thought to be best resolved at the departmental level.

> "I am not anxious to get involved. I prefer them to resolve it at that level.... If a problem arises, I attempt to direct them what to do. That's my day-to-day activities. They have to make decisions and I help by giving them advice. I can't be concerned with this since the overall policy is the goal. That's why I have department heads - to look after these problems."

Again, the generalist and integrative functions were hinted at by the fact that this administrator, like all the others, provided advice and policy interpretation to his subordinates to help them make decisions. The attempt to give direction to the organization and its members, as well as attempting to ensure that activities of departments were integrated, usually left the administrator outside direct areas of decision-making in the socio-technical sector, while at the same time forcing him into those areas when decisions could not be made. "If they can't solve the problem, then I make the decision."

The appearance of standing outside the socio-technical system and being minimally influenced by it, however, clearly is not an accurate picture, especially when a crisis occurs in this sector. Because of the routinization of meetings in which, for example, departmental budgets are resolved, this appearance is reinforced. Nevertheless, the administrator becomes directly involved in these processes and his role is organized around these processes, either through having to resolve or provide advice to department heads about problems, or through participation in routinized meetings. In all instances, the role of integrating on-going activities in the socio-technical sector stem from his responsibilities to the board "...to see that policy gets implemented."

At the time the data was collected, the decision had been made by the hospital board to extend a new program of nursing care. Specifically, the changes in patient care practices which had been instituted on the surgical ward, were being introduced into the obstetrics and gynecology ward. In order to introduce these changes, the nursing director indicated that:

> "We had numerous meetings prior to instigation of the program. Upon instigation we had constant meetings three times a week. Problems were dealt with mainly through interdepartmental meetings. Part of the problem was also introducing new types of personnel as well as upsetting modes of working. ...It really boiled down to a problem of change and role conflict....Nurse-physician conflict was high at the time we introduced the changes."

Table 1, Appendix A, suggests that, while "Committees and meetings have been reduced in frequency now," the effect of the change appeared to be continuing, in that most of the personnel felt they had at least a medium degree of involvement in decision-making at the departmental level in committees.

The change in nursing care techniques had other consequences. Not only the wards in which the changes were being introduced were involved in role conflict, but other departments, and especially "...obstetrics were threatened by the change." Furthermore, the conflict between nursing personnel and physicians was paralleled at the managerial level where the executive committee of the medical staff resigned. This ability to resign, indeed the ability to engage in "inter-hospital competition by the doctors," as the nursing director put it, may have been due to the fact that the physicians had privileges in both the town's hospitals, Southern Municipal and Southern Religious. Indeed, both the administrator and the nursing director stated that the question had been: "Who runs the hospital?"

This system wide conflict, then, affected both the socio-technical and managerial sectors of the organization. Concern for the consequences, both of the change, and of the ensueing nurse-physician conflict, figured prominently in the interviews with the hospital administrator and the nursing director. Concern with both the medical staff and nursing departments was evident even after a two year period had passed since the initial data collection phase. This concern and careful monitoring of these areas of the socio-technical systems appeared to be justified from an analysis of the data.

A comparison of Southern Municipal and Southern Religious Hospitals suggests a somewhat more positive organizational climate in Religious than in Municipal. Comments among nursing staff and community members also implied a higher valuation of Southern Religious. Some comments by personnel indicated that Southern Religious "...was concerned more with its personnel." "They appreciate you and your work more there." "They're not always changing things. (Southern Municipal) has changed its wards twice so far and they're doing it again." The bases of these external comments were unknown, but suggested an awareness of what Tables 1-53, Appendix A indicate - a lower organizational climate as compared to Midland and Southern Religious. In many aspects, Southern Municipal was more like Urban Hospital.

For example, the human relations skills of the supervisors were rated as high by fewer of the personnel, as compared with the respondents in Midland and Religious Hospitals (Tables 9-12, Appendix A). The administrative skills of the supervisors were also not as likely to be rated high, as compared to the other medium sized hospitals (Tables 13-16, Appendix A).

Despite these lower evaluations, the administrator and director of nursing indicated an awareness and concern for this aspect of their organization. As a critical component of the administrator's "arena of action," the nursing director indicated that:

> "He was most supportive of the nursing department during that time. I know he feels he might have done more for one of the head nurses. But he really tried. He was wonderful and kept the board behind us and tried to handle the problems with the doctors."

This statement raises the interesting implication of the consequences of the dual authority system combined with the impact of organizational change. That is, the nurse-physician conflict, as a consequence of organization and bureaucracy, has been well documented.[28] In comparison with the other hospitals, however, the implication was that the change either increased or highlighted this conflict. The attempt to remove some of the sources of conflict from the nurse-practitioner relationships was evident both in the administrator's attempt to buffer the nursing sectors from external fluctuations, and the recognition of the need stated by the administrator of the pre-test hospital:

"It is necessary to work out the problems before they

> affect our nurses. We have these meetings (reference to J.C.C.) to make sure there is agreement and understanding about the problem and what will be acceptable to do about them. Otherwise we'd have havoc on our nursing wards. It would fall on nursing to resolve the differences between physicians and the administration, and that's not their job."

A breakdown at the level of the management triangle of Southern Municipal or at least a strain in the relationships at that level, appeared to show up in the wards where change was being introduced. At the same time, however, this strain affected the relationship at the administrator-physician-board level. Changes in patient care practices, or the "quality of patient care" appeared to be a precursor to the conflict between the board and the medical staff.

Other factors that contributed to the conflict, however, may have been the lack of routine meetings of the J.C.C. in this hospital, since they met "only when necessary," even though that had been ten times that year. Furthermore, the staff appeared to "...resent his (the administrator's) close ties with the board. The staff aren't too sure how seriously their needs are considered." Furthermore, the medical staff had privileges in both hospitals, which not only was a unique situation, but gave the staff a position of power to promote competition between the hospitals. That is, their dependency on one hospital in order to perform their work, was considerably reduced.

Other organizational factors reflected the lower organizational climate of the hospital. It was reflected in the lower degree of job satisfaction, excluding, of course, satisfaction with wages and salaries, and promotional opportunities

(Tables 17-23, Appendix A).

Intra-departmental coordination (Table 24, Appendix A), and role conflict and role ambiguity (Tables 26-42, Appendix A), also reflected the fact that, at the time of the project, this hospital - compared to the other medium sized organizations, appeared to be experiencing sufficient change to adversely affect the environment of the hospital. Furthermore, this change and resulting system wide disruption, while affecting the relationship at the administrative level, may also have been partly exacerbated by the relationships at the managerial and institutional levels of the organization.

Southern Religious Hospital

This was a medium sized religious institution. The administrator, therefore, was a member of a religious order, and bound, as was the hospital, by certain constraints established by that religious order. Despite these constraints, for example on capital acquisitions, plant extension, and on "the selection and appointment of the treasurer and the administrator, the operation of the hospital (was) basically the same" as other nonsectarian hospitals. Of course, the operation of the organization and the kinds of tasks performed or not performed, such as abortions, were also affected to some degree.

In contrast to the situation of the administrator at Municipal, the board, medical staff and administrator relationships were described as "good here."

The administrator of Southern Religious, like the other administrators, emphasized good human relations skills, utilized reports and committees as feedback, delegated task areas and utilized committees as a place to "...relay information, establish procedures and changes in procedures, and to deal with interdepartmental problems." Furthermore, the administrator of Religious recognized the use of "...one to one discussions. I do a great deal of this with the major departments."

In essence, much of the administrator's role, as that was organized around and enacted through the administrative process, was basically similar to that of the other administrators. The absence of a strong external orientation towards the environment distinguished this administrator from Urban administrator. Neither was there as great an emphasis on medical staff issues as was the case with the Midland administrator, nor as great a concern about the difficulties which the nursing departments were experiencing due to a change in techniques, as was characteristic of the administrator of Municipal.

The administrator of Southern Religious, however, was somewhat like the Midland administrator in the concern with attending the Medical Advisory Committee of the medical staff and the recognition of it as being

> "...valuable in their accepting me. I think the medical staff appreciate this. I get a chance to relay information as a group, and it serves as a clarification function."

Indeed, the nursing director pointed out that the nursing staff

> "...seek the administrator's advice about plans and fix them up so that the medical staff will accept the plan."

The use of the formal medical staff organization was also recognized as a means to influence the medical staff.

> "I talk to the chief of staff or the president - or I go to the clinic head about a problem. If a recommendation is accepted it goes to the MAC. I rely on someone who has an interest in a particular area to get recommendations made."

> "My main contact with the medical staff is through the chief of staff - should always go through him first of all."

As has been pointed out already, however, the administrator of Religious resembled the other administrators in the style of administration. The finance director, for example, indicated that the style was:

> "...low key. A lot of consulting is done and delegation of authority - can be tough when - wants to be."

And the nursing director indicated that:

> "This administrator is more open. I've seen three administrators, and this one is more open."

Religious administrator also resembled Midland administrator in that both directors of nursing felt that they had a "...pretty free hand in my job here."

The style of the administrator, plus the process of delegating, and the emphasis on human relations skills, were felt to be part of the answer to the satisfaction of the employees. As the nursing director indicated:

> "I think we have a lot of happy workers here. At least that's what I am told by the people here and in the community....Contracts with the staff reduce the administrator-staff conflict by specifying expectations - we have a good personnel program here and try to make sure that people are recognized for their work."

These subjective feelings that the personnel of the hospital participated in the organization and generally felt a high degree of job satisfaction with the job and supervision, at least as compared with the staff in Municipal Hospital, appeared to be borne out in the data.

Indeed, Midland and Religious were most nearly alike, and both hospitals ranked either first or second on the different organizational factors. The expectation that the organizational climate was positive, and subsequent actions by the administrator and the nursing director, appeared to be closely interrelated. For example, the perception that job satisfaction was high is borne out in Table 17, Appendix A, where Southern Religious ranked first in the proportion expressing high total job satisfaction. Tables 18-23, Appendix A, also support the feelings that job satisfaction of the personnel was high.

The feeling that the personnel experienced a more structured environment also tends to be borne out in Table 24, Appendix A, where Southern Religious ranked second in the proportion of the personnel reporting high intra-departmental coordination. In most instances, Southern Religious ranked third in the degree of role conflict and role ambiguity experienced by the staff and personnel (Tables 26-42, Appendix A).

Furthermore, respondents in Religious were similar to those in Midland in reporting less bureaucracy (Tables 43-48, Appendix A). While high involvement was reported in formal decision-making modes (Table 1, Appendix A) and in informal decision-making (Table 2, Appendix B), Religious was intermediate in terms of the extent of negotiation reported.

In general, the social structure of Southern Religious was most similar to Midland, and in terms of ranking on participative and high organizational climate, ranked either first or second depending on the organizational factor considered. Furthermore, both administrators closely resembled each other in terms of orientation towards the medical staff and the administrative process through which they enacted their role.

IV. CRITICAL AREAS OF HOSPITAL OPERATION

Some further understanding of the differences in administrator behavior, vis-a-vis their organizational contexts, can be obtained by analyzing the evaluations of the Areas of Hospital Operation questionnaire material.

Prall, in 1948, surveyed administrators in the United States to determine how important they felt different areas were in the operation of the hospital.[29] Dolson modified Prall's original instrument and surveyed administrators in 1963.[30] Comparison of the results of the two studies indicated that, in 1963, administrators ranked department heads and departmental functioning as the most critical area, whereas in 1948 they ranked these areas third most important. In contrast, medical staff issues were ranked first in importance in 1948 and fourth in 1963. Business and finance, ranked fifth most important in 1948, was second most important in 1963 followed by personnel management. This latter area was second in importance to the administrators whom Prall surveyed. The remaining items tended to show greater agreement between the two time periods with only minor shifts in ranking.

Table 36 presents the rankings for the Prall and Dolson studies, including the rankings by the administrators and their administrative counter-role assistants in the present study.*

There was very little agreement, either between encumbents of the same roles, or between counter-role partners. The administrator of Urban Hospital showed the greatest deviation from the Prall-Dolson studies. In contrast, as in the Dolson study, department heads and departmental functioning were considered high in importance by the counter-role assistants of the administrator of Urban Hospital. These latter responents were also similar to the administrator and counter-role assistants of Midland Hospital in their rankings of the areas. The fact that the administrator of Urban Hospital diverged so much from previous studies may be due to the fact that many of these areas of concern had been delegated by him to his counter-role assistants, whose rankings of the twelve areas - were much more similar to the previous studies.

The relatively high rank that the administrators of the medium sized hospitals assigned to medical staff, board, and business and financial management, may also indicate their more immediate and direct involvement in these areas since they were, organizationally, directly responsible for these

*Counter-role assistants were defined as including at least assistant administrators and nursing directors, and, where relevant, medical, financial or business directors, and personnel directors. Aside from the first two positions, what constituted the administrative role set of the administrator had to be determined in each hospital, and positions, therefore, sometimes varied. The result of this was that some administrators' role set was slightly larger than other administrators'.

TABLE 36
COMPARISON OF RANKINGS ON CRITICAL AREAS OF OPERATION: PRALL, DOLSON, AND STUDY RANKINGS

Area of Operation	Past Studies Prall 1948	Past Studies Dolson 1963	Administrator Response HOSPITAL Urban	Administrator Response HOSPITAL Midland	Administrator Response HOSPITAL Religious
1. Administrative department heads and departmental functioning, including nursing and special services.	3	1	9	1	2
2. Business and financial management.	5	2	9	4	3
3. Community relationships, including relations with other hospitals, with local health and welfare agencies and public relations in general.	6	6	5	6	8
4. Education programs.	-	9	4	10	9
5. External controls (governemental regulations and so forth).	9	10	10	9	10
6. Governing Board.	8	7	10	3	1
7. Legal aspects and litigation.	10	11	9	12	11
8. Medical Staff.	1	4	10	2	4
9. Personnel management and employee relations.	2	3	9	5	7
10. Physical plant and equipment including construction.	7	8	4	7	6
11. Planning patient care services and facilities.	4	5	5	8	5
12. Research Programs.	-	12	3	11	12
NUMBER OF RESPONDENTS			1	1	1

The administrator of Municipal did not complete this questionnaire.

TABLE 36 CONTINUED
COMPARISON OF RANKINGS ON CRITICAL AREAS OF OPERATION: PRALL, DOLSON, AND STUDY RANKINGS

Area of Operation	Counter-Role Response HOSPITAL Urban	Midland	Municipal	Religious
1. Administrative department heads and departmental functioning, including nursing and special services.	1.6	1.6	4.5	3.6
2. Business and financial management	3.4	1.3	4.5	4.3
3. Community relationships, including relations with other hospitals, with local health and welfare agencies and public relations in general.	7.4	4.3	10	7.3
4. Education programs	7	4	8	9.3
5. External controls (governmental regulations and so forth).	6.4	5.3	10	6.6
6. Governing Board	5	2.6	3	3.3
7. Legal aspects and litigation.	8.2	7	10.5	9
8. Medical Staff.	3	3	3	3
9. Personnel management and employee relations.	4	5.6	7	3.3
10. Physical plant and equipment including construction.	5.4	2.6	3	6.6
11. Planning patient care services and facilities.	5.8	1.6	3	5.3
12. Research Programs	10.8	5.3	11.5	12
NUMBER OF RESPONDENTS	5	3	2	3

areas. That is not to say that the administrator of Urban Hospital was not responsible to or for these same areas. It does imply, however, that the very structure of management in this organization may have helped to reduce the situational demands on the administrator from these areas, while the other administrators would more directly experience these demands.

Unlike the management structure in the smaller organizations, a set of assistant executives could act as buffers, since each is responsible for an area of the hospital's operation and reports directly to the administrator. The administrator would then function as "a resource person," as one of his assistants put it. On the other hand, while the assistant would be subjected to the more direct impact of the internal variations in the organization, the administrator of Urban Hospital would in turn buffer his assistants and the internal organization from external sources of variation. Thus, having a medical director may reduce some of the immediate concerns with the medical staff. Indeed, the administrator of Midland suggested this difference in comparing his hospital with that of Urban.

Finally, the results reported here, not only suggest that some differences are due to inter-position constraints, but that size of the sample permits a free rein to the influence of personal philosophy. Granted there is a close link between position and ideology, but the survey techniques used by Dolson and Prall had the advantage of depressing the effect of personal philosophy and enhancing the effect of position. The opposite effect is more apparent in this study.

While that limits the usefulness of comparing the study results with the earlier projects, the results do summarize the work environment of each of the administrators as they perceived it.

Thus, research and education programs, the planning of patient care facilities, and physical plant and community relationships were seen as more critical areas of operation to the administrator of Urban, while departmental functioning, financial management, governing boards and medical staff concerns were greatest for the hospital administrators of Midland, Municipal and Religious Hospitals.

V. SUMMARY

This chapter began with a descriptive analysis of the organizational climates and structures of the hospitals participating in this study. In general, the organizational climates across hospitals were described as positive, normative and participative. While bureaucracy was relatively low, negotiation tended towards medium to high degrees of such accommodative behavior.

An attempt at a limited intercorrelational analysis revealed that the normative, participative organization is achieved through a complex pattern of interrelationships. A central set of variables in this analysis turned out to be the three supervisory skills. While each skill tended to be more strongly correlated with different organizational variables, the three skills were positively correlated with such factors as formal and informal decision-making, job satisfaction, inter-departmental relations and coordination, and were negatively correlated with role conflict and ambiguity.

In addition, the intercorrelations between bureaucracy and negotiation, discussed in Chapter IV, suggested that in organizations like acute care institutions, which employ an intensive technology, the organizational bureaucracy stimulates and supports negotiatory behavior. In turn, however, negotiatory behavior, through both formal and informal channels, makes it possible for the bureaucracy to function. It was suggested that the normative, participative and positive organizations described in this chapter, were partly based on the type of technology employed, as well as on the interrelationships that exist between bureaucracy and negotiation.

The analysis of the specific organizational contexts and administrative structures in each of the hospitals revealed both similarities and differences among the hospitals. In general, Midland and Southern Religious were similar and most positive. Respondents in these hospitals expressed greater job satisfaction, better inter-departmental relations and coordination, and less role conflict and ambiguity than did respondents in Urban and Southern Municipal. These latter two institutions were more similar to each other than they were to the former two hospitals. While Midland and Religious tended to rank either first or second depending on the organizational dimension under study, Municipal tended to rank third and Urban tended to rank fourth. It should be remembered, however, that these rankings existed within the generally favourable or positive organizational climates that prevailed across the four institutions.

While all administrators delegated task areas to assistants and acted within an integrative-information processing role, Urban administrator had the most extensive role set of the four hospitals. In addition Urban administrator had the greatest awareness and concern for an external orientation. His concern for the dehumanizing characteristics of a large complex organization, and his subsequent efforts, to reduce this dehumanization, appeared to be justified by the data.

Midland administrator differed somewhat from the other administrators in the organization of his role around medical staff concerns. The administrator of Southern Religious however, resembled the Midland administrator in this regard, as did the organizational structures of these two hospitals resemble one another. It was suggested that the organization of the role of Midland administrator, as well as the administrative process in this hospital, was attributable to the personalities of both the administrator and the nursing director, the power of the nursing director, and the very positive organizational climate which helped to support the administrative pattern in this hospital.

While the administrator of Southern Municipal resembled the other administrators in the delegation of task areas and the coordinative-information processing role that was enacted by all administrators, the system wide conflict caused by changes in nursing care techniques pointed to some differences in administrator behavior. Specifically, the changes that were introduced appeared to highlight or reinforce the conflict at the managerial level. Close administrator/board relationships and ensuing physician mistrust, the lack of regularized meetings of the Joint Conference Committee, and the power of the physicians to promote inter-hospital competition due to their dual privileges in Municipal and Religious, may partly explain this conflict. The lack of a "...viable staff organization" at the time of the study also may have contributed to the conflict stimulated by the changes that were introduced into the nursing care sectors of the hospital.

While the administrator of Southern Religious was a member of a religious order, the administrative process and the structure of administration were similar to the other non-sectarion institutions. This administrator, however, was most like the administrator of Midland in orientation towards the medical staff, although not to the same degree. In addition, the organizational climate was more nearly like Midland.

In general, the consultative-participative managerial structures appeared to be based on positive, normative socio-technical structures. Differences in administrative processes and aministrator roles existed and appeared to be due to different factors, including complexity and size of the organization, personality factors, organizational change, administrator-board-medical staff relationships, and, importantly, the characteristics of the socio-technical environments.

FOOTNOTES

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3. See Tables 31-33, Appendix A.

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21. W.R. Rosengren and Mark Lefton, Hospitals and Patients (New York: Atherton Press, 1969), Part I. For a discussion about Canada's health care system relative to this concept see also: John Hastings, The Community Health Care in Canada (Ottawa: Queen's Printer, 1972).

22. Lawrence R. Tancredi and John Woods, "The Social Control of Medical Practice: Licensure versus Output Monitoring," Milbank Memorial Fund Quarterly, 1(January, 1972), Part I, pp. 99-125.

23. For an excellent insight into the latent hostility and distrust between nursing staff and "the administration, see Carol Taylor, In Horizontal Orbit (New York: Holt, Rinehart and Winston, 1970). The author's style betrays an expectation that the administrator is too restrictive of the autonomy of the nursing staff.

24. Peter F. Drucker, The Practice of Management (New York: Harper and Row, 1954).

George I. Morrisey, Management By Objectives and Results (Addison-Wesley, 1970), p. iv. "Stated simply, Management By Objectives and Results...involves a clear and precise identification of objectives or desired results, the establishment of a realistic program for their achievement, and an evaluation of performance in terms of measured results in attaining them. The process of accomplishing these steps is, however, much more complex."

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trators tried to relate the substance of the call to the interviewer. The social psychology of the telephone call and how to use it as a research instrument may be a valuable unobtrusive device!

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CHAPTER VI

ROLE CONCEPTIONS AND ADMINISTRATIVE PROCESSES

The focus of attention in this chapter is on the role of the administrator in the management triangle, as that role is articulated through the role conceptions of the administrator's role senders. In addition, concern is directed at the administrator's role within the framework of the administrative process and structure. With respect to these two concerns, attention is given to the general patterns which exist across hospitals. An analysis of specific cases will be conducted when the administrative pattern within that hospital particularly highlights the general pattern, or where it differs significantly from general patterns. A more detailed analysis of administrator behavior within each separate organization has already been conducted in the latter part of the preceding chapter.

Both questionnaire and interview data are used to analyze the role of the administrator. However, greater use is made of questionnaire data in the first part of this chapter, while interview data is used in the latter part of this chapter.

I. ROLE CONCEPTIONS

The roles conception data is used to test two hypotheses and their corollaries. The analysis of the data relevant to these hypotheses follows immediately below.

Hypothesis Nine

> The Kendall Coefficient of Concordance (W) will be higher for traditional than for nontraditional areas of administrator responsibility.

The data relevant to Hypothesis Nine is presented in Table 37. Sixteen of the 28 traditional area items are greater than one, whereas only 4 of the 35 nontraditional items are greater than one. As Siegel has pointed out, the greater the W the more likely that a set of judges are in agreement in ranking some object.[1] The data presented here indicate that board members, medical staff, administrators and administrators' counter role assistants are in greater agreement on traditional than on nontraditional items. Hypothesis nine is therefore supported.

Hypothesis Nine: Corollary One

> The average median response for all respondent groups will be between one and two for traditional areas and between two and four for nontraditional areas of hospital administrator expectations.

While the data for hypothesis nine indicates greater agreement among the respondent groups for traditional than nontraditional areas, it does not indicate the extent of power the administrator should have in relation to the other two groups of the management triangle. Therefore, the average median response was computed for administrator responsibility items in order to test Corollary One. This data is reported in Table 38, columns 3 and 10.

In 11 of the 28 traditional items the average median response ranged between 1.50 and 2 or higher. In only 1 case

TABLE 37

ROLES CONCEPTIONS BY RESPONDENTS

Traditional Areas

1. When nursing staff and other personnel request raises in salary and wages.

	Respondent Groups Median Response				
	1	2	3	4	W
BT	4	4	4	4	1.7
MS	4	4	4	4	
ADM	2	2	2	2	

2. When a decision must be made to join a group purchasing plan.

	Respondent Groups Median Response				
	1	2	3	4	W
BT	1	1	1	1	1.02
MS	3	3	3	3	
ADM	2	2	2	2	

3. When policy regarding admission practices must be made.

	Respondent Groups Median Response				
	1	2	3	4	W
BT	1	1	2	1	4.66
MS	2	2	1	2	
ADM	2	2	2	2	

4. When disagreements arise between the head of a clinical department and the head of a service department.

	Respondent Groups Median Response				
	1	2	3	4	W
BT	4	3	2	3	1.02
MS	2	2	2	2	
ADM	1	1	2	1	

5. When equipment is not being utilized to the capacity that had been estimated when purchased, thereby raising the cost of operation and requiring some adjustment in use.

	Respondent Groups Median Response				
	1	2	3	4	W
BT	3	2	2	3	.57
MS	2	2	2	2	
ADM	1	1	2	1	

6. When an appointment for a hospital administrator is to be made prior to the retirement of a present incumbent.

	Respondent Groups Median Response				
	1	2	3	4	W
BT	1	1	1	1	.95
MS	4	2	2	3	
ADM	3	2	3	2	

7. When a decision must be made to resolve a disagreement between the purchasing agent and the head of a Clinical department about the possiblity that a similar supply item might be equally effective at less cost.

	Respondent Groups Median Response				
	1	2	3	4	W
BT	4	3	3	3	1.27
MS	3	2	2	2	
ADM	1	1	1	1	

8. When a budgetary control system for departments must be set up.

	Respondent Groups Median Response				
	1	2	3	4	W
BT	1	2	1	3	.94
MS	3	3	2	3	
ADM	1	1	1	1	

9. When a decision to hire a Personnel Director is to be made.

	Respondent Groups Median Response				
	1	2	3	4	W
BT	1	1	1	3	.19
MS	4	3	3	4	
ADM	1	2	2	1	

10. When the services of a medical service department have been utilized in such a way as to exceed the operating budget and a decision as to the remedial action to take must be made.

	Respondent Groups Median Response				
	1	2	3	4	W
BT	3	1	1	3	.21
MS	2	2	2	2	
ADM	1	1	2	1	

11. When a decision must be made as to what insurance the hospital is to carry and for what purposes.

Respondent Groups Median Response

	1	2	3	4	W
BT	1	1	1	1	1.27
MS	4	3	3	3	
ADM	2	2	2	2	

12. When a decision is to be made about what policy to follow regarding visitor hours.

Respondent Groups Median Response

	1	2	3	4	W
BT	1	1	2	1	.19
MS	2	2	2	2	
ADM	2	1	1	2	

13. When a decision is to be made as to what policy to follow concerning what should be released to the news media and who should be allowed to release information.

Respondent Groups Median Response

	1	2	3	4	W
BT	1	1	2	1	.19
MS	2	2	2	2	
ADM	2	1	1	1	

14. When a Medical Record librarian is to be selected and hired.

Respondent Groups Median Response

	1	2	3	4	W
BT	4	3	2	4	1.59
MS	3	3	2	3	
ADM	1	1	1	1	

15. When a grievance is made by the members of a hospital's service department concerning the head of that department.

Respondent Groups Median Response

	1	2	3	4	W
BT	4	3	2	3	1.77
MS	1	1	1	1	
ADM	1	1	1	1	

16. When the operating budget for the next fiscal year must be determined.

Respondent Groups Median Response

	1	2	3	4	W
BT	1	1	1	1	.66
MS	2	3	2	3	
ADM	2	2	2	2	

17. When complaints have been received about the food service provided.

Respondent Groups Median Response

	1	2	3	4	W
BT	3	3	2	3	1.46
MS	3	3	3	3	
ADM	1	1	1	1	

18. When a decision must be made about personnel practices when wages and salaries are rising but funds for operating the hospital are not.

Respondent Groups Median Response

	1	2	3	4	W
BT	1	1	1	1	1.08
MS	3	3	3	3	
ADM	2	1	2	2	

19. When personnel who have served the hospital for a long time are to be honored.

Respondent Groups Median Response

	1	2	3	4	W
BT	1	1	1	1	1.46
MS	4	3	2	3	
ADM	2	1	1	1	

20. When a disagreement between the Nursing Director and the head of a clinical department has arisen.

Respondent Groups Median Response

	1	2	3	4	W
BT	3	3	2	3	.82
MS	2	2	2	2	
ADM	1	1	1	1	

21. When employee turnover is high in a nursing unit and some action must be taken.

Respondent Groups Median Response

	1	2	3	4	W
BT	3	3	3	3	1.46
MS	3	3	2	3	
ADM	1	1	1	1	

22. When problems of coordinating the services provided by the hospital service departments arise.

Respondent Groups Median Response

	1	2	3	4	W
BT	4	3	3	3	1.59
MS	3	3	2	3	
ADM	1	1	1	1	

23. When a decision whether to engage a hospital consultant in housekeeping and infection must be made.

Respondent Groups Median Response

	1	2	3	4	W
BT	1	1	1	1	.36
MS	2	2	2	2	
ADM	2	2	1	2	

24. When a decision whether or not to renovate the existing plant must be made.

Respondent Groups Median Response

	1	2	3	4	W
BT	1	1	1	1	.44
MS	2	2	2	2	
ADM	2	2	2	2	

25. When procedural rules and policies affecting the working relationships between nursing departments and service departments must be changed.

Respondent Groups Median Response

	1	2	3	4	W
BT	4	2	2	3	1.66
MS	3	3	2	3	
ADM	1	1	1	1	

26. When personnel policies are to be determined and decided upon.

Respondent Groups Median Response

	1	2	3	4	W
BT	1	1	1	1	1.87
MS	4	2	3	4	
ADM	1	1	1	2	

27. When disagreements between the heads of clinical departments arise.

Respondent Groups Median Response

	1	2	3	4	W
BT	3	3	3	3	1.46
MS	1	1	1	2	
ADM	1	1	1	1	

28. When a decision must be made to resolve a disagreement between the purchasing agent and the head of a Service department regarding the possibility that a similar supply item might be equally effective at less cost.

Respondent Groups Median Response

	1	2	3	4	W
BT	4	3	3	3	1.39
MS	3	3	2	3	
ADM	1	1	1	1	

Non-Traditional Areas

1. When a decision must be made to share laundry facilities with another hospital in a city or region.

Respondent Groups Median Response

	1	2	3	4	W
BT	1	1	1	1	1.58
MS	3	4	3	4	
ADM	2	2	2	2	

2. When an appointment for a Director of Nursing must be made.

Respondent Groups Median Response

	1	2	3	4	W
BT	1	1	1	1	.58
MS	3	2	2	3	
ADM	1	1	2	2	

3. When a set of Medical Staff by-laws must be developed for a general hospital.

Respondent Groups Median Response

	1	2	3	4	W
BT	1	1	2	1	.19
MS	2	2	1	2	
ADM	2	2	2	2	

4. When decisions must be made about purchasing a major piece of equipment considered necessary for good patient care.

Respondent Groups Median Response

	1	2	3	4	W
BT	1	1	1	1	.44
MS	2	2	2	2	
ADM	2	2	2	2	

5. When the drug variance is higher than standards considered acceptable.

Respondent Groups Median Response

	1	2	3	4	W
BT	3	2	3	3	.58
MS	2	2	1	2	
ADM	1	2	2	1	

6. When a decision must be made to share medical service facilities with another hospital.

Respondent Groups Median Response

	1	2	3	4	W
BT	1	1	1	1	.44
MS	2	2	2	2	
ADM	2	2	2	2	

7. When a decision to seek an accreditation survey must be made and it is financially possible.

Respondent Groups Median Response

	1	2	3	4	W
BT	1	1	1	1	.44
MS	2	2	2	2	
ADM	2	2	2	2	

8. When a decision must be made to share the services and costs of professional service personnel, such as a pathologist, with another hospital.

Respondent Groups Median Response

	1	2	3	4	W
BT	1	1	1	1	.44
MS	2	2	2	2	
ADM	2	2	2	2	

9. When a decision to prepare a regular monthly service report for physicians' information must be made.

Respondent Groups Median Response

	1	2	3	4	W
BT	3	3	3	3	.82
MS	2	2	2	2	
ADM	1	1	2	1	

10. When a decision to suspend admitting privileges of a physician due to incomplete medical records must be made.

Respondent Groups Median Response

	1	2	3	4	W
BT	1	1	2	3	.02
MS	2	1	1	2	
ADM	2	2	2	1	

11. When a Joint Conference Committee meets to hear the appeal of a staff member who has not been recommended for reappointment.

Respondent Groups Median Response

	1	2	3	4	W
BT	1	1	1	1	.36
MS	2	2	1	2	
ADM	2	2	2	2	

12. When a decision to participate in the Professional Activity Study must be made.

Respondent Groups Median Response

	1	2	3	4	W
BT	1	2	2	1	.11
MS	2	1	1	2	
ADM	2	2	2	2	

13. When a decision whether or not to introduce a "unit-dose-packaging system" must be made.

Respondent Groups Median Response

	1	2	3	4	W
BT	3	3	3	2	.65
MS	2	2	1	2	
ADM	1	1	2	1	

14. When a "value-analysis" of certain standardized medical materials must be made.

Respondent Groups Median Response

	1	2	3	4	W
BT	3	3	3	3	.95
MS	2	1	1	2	
ADM	1	1	2	1	

15. When a decision must be made as to what health needs of the community a hospital should and should not provide.

Respondent Groups Median Response

	1	2	3	4	W
BT	1	1	1	1	.44
MS	2	2	2	2	
ADM	2	2	2	2	

16. When a decision as to what policy to follow and the rules to be implemented has to be made concerning the suspension or retirement of physicians from the Medical Staff.

Respondent Groups Median Response

	1	2	3	4	W
BT	1	1	2	1	.19
MS	2	1	1	2	
ADM	2	2	2	2	

17. When a lawsuit is being brought against the hospital for negligence on the part of hospital personnel and some course of action must be determined.

Respondent Groups Median Response

	1	2	3	4	W
BT	1	1	1	1	.66
MS	3	3	2	2	
ADM	2	2	2	2	

18. When a decision is to be made as to hiring a qualified person for the position of Medical Director and what his duties will be.

Respondent Groups Median Response

	1	2	3	4	W
BT	1	1	1	1	.48
MS	2	2	2	3	
ADM	1	2	2	2	

19. When conflicts between members of the Medical Staff and hospital personnel arise.

Respondent Groups Median Response

	1	2	3	4	W
BT	3	2	2	3	.66
MS	2	2	2	2	
ADM	1	1	1	1	

20. When a decision about the location and sharing of costs and facilities for an outpatient clinic among the hospitals of a community must be made.

Respondent Groups Median Response

	1	2	3	4	W
BT	1	1	1	1	.44
MS	2	2	2	2	
ADM	2	2	2	2	

21. When the Medical Staff by-laws must be reviewed and revised.

Respondent Groups Median Response

	1	2	3	4	W
BT	1	1	2	1	.19
MS	2	1	1	2	
ADM	2	2	2	2	

22. When connections with other hospitals and local health and welfare agencies are to be made to promote efficient utilization and better planning of health care facilities.

Respondent Groups Median Response

	1	2	3	4	W
BT	1	1	1	1	.44
MS	2	2	2	2	
ADM	2	2	2	2	

23. When decisions as to the scheduling of operating room hours are to be made.

Respondent Groups Median Response

	1	2	3	4	W
BT	4	4	3	2	1.92
MS	1	1	1	2	
ADM	1	1	2	1	

24. When policy and procedures must be developed concerning intern and residency programs.

Respondent Groups Median Response

	1	2	3	4	W
BT	3	3	2	3	.82
MS	2	2	2	2	
ADM	1	1	1	1	

25. When a decision must be made about whether or not to provide bed space for a proposed research project when bed space is limited.

Respondent Groups Median Response

	1	2	3	4	W
BT	1	1	2	1	.19
MS	2	2	1	2	
ADM	2	2	2	2	

26. When it is felt that the emergency department of a hospital is overburdened with nonemergency cases and some action must be taken to relieve the pressure.

Respondent Groups Median Response

	1	2	3	4	W
BT	1	1	2	1	.19
MS	2	2	1	2	
ADM	2	2	2	1	

27. When planning for additional patient care services is felt to be necessary.

Respondent Groups Median Response

	1	2	3	4	W
BT	1	1	1	1	.44
MS	2	2	2	2	
ADM	2	2	2	2	

28. When procedures and policies regarding the use of disposable items must be developed.

Respondent Groups Median Response

	1	2	3	4	W
BT	3	3	3	3	1.0
MS	2	2	2	2	
ADM	1	1	1	1	

29. When adequate procedures for the disposal of kitchen and laboratory waste must be decided upon.

Respondent Groups Median Response

	1	2	3	4	W
BT	3	3	3	2	1.18
MS	3	3	3	3	
ADM	1	1	1	1	

30. When the hours of an outpatient clinic are to be decided upon.

Respondent Groups Median Response

	1	2	3	4	W
BT	3	3	3	1	.42
MS	2	2	1	2	
ADM	1	1	2	1	

31. When a community relations program is to be set up and decided upon.

Respondent Groups Median Response

	1	2	3	4	W
BT	1	1	1	1	.53
MS	3	2	2	2	
ADM	2	2	2	2	

32. When accreditation status has been lost and the remedial actions to take are to be determined.

Respondent Groups Median Response

	1	2	3	4	W
BT	1	1	1	1	.44
MS	2	2	1	2	
ADM	2	2	2	2	

33. When dissatisfaction with the head of a clinical department is expressed by members of the Medical Staff.

Respondent Groups Median Response

	1	2	3	4	W
BT	1	2	2	2	.05
MS	2	2	1	2	
ADM	2	2	2	2	

34. When problems of coordinating the services of the clinical departments arise.

Respondent Groups Median Response

	1	2	3	4	W
BT	3	3	3	3	.81
MS	2	2	1	2	
ADM	1	1	2	1	

35. When it is felt that the Medical Staff organization should be reviewed and changes should be made.

Respondent Groups Median Response

	1	2	3	4	W
BT	1	1	2	1	.46
MS	2	2	1	1	
ADM	2	2	2	2	

Respondent Groups

1 = Administrator

2 = Board of Trustees

3 = Medical Staff

4 = Administrator's Counter Role Assistants

W = Kendall's Coefficient of Concordance

Stimulus Groups which Respondent Groups Rate on Items.

BT = Board of Trustees

MS = Medical Staff

ADM = Administrator

TABLE 38
TRADITIONAL ITEMS

		ADMINISTRATOR		BOARD		MEDICAL STAFF	
28	1	2	3	4	5	6	7
Question	W	FMD	Median	Median	FMD	Median	FMD
1	1.7		2	4	57.14	4	57.14
2	1.0	73.00	2	1	100.09	3	21.93
3	.19	69.54	2	2	19.67	1	64.08
4	1.02	66.70	1.25	3	55.97	2	56.60
5	.57	63.96	1.25	2	19.80	2	69.41
6	.95	33.68	2.50	1	148.00	2	62.61
7	1.27	69.86	1	3	89.06	2	59.88
8	.94	75.67	1	2	27.86	2	44.29
9	1.4	59.67	1.50	1	90.19	3	29.14
10	.21	61.89	1.25	1	52.00	2	85.66
11	1.27	78.55	2	1	127.12	3	35.36
12	.19	67.58	1.50	2	23.23	2	73.11
13	.19	60.66	1.25	1	55.69	2	55.64
14	1.59	86.71	1	3	12.23	2	35.12
15	1.77	87.18	1	2	50.97	2	10.16
16	.66	83.92	2	1	121.05	2	44.29
17	1.46	115.62	1	2	10.70	3	54.79
18	1.08	70.33	1.75	1	112.03	3	37.85
19	1.46	61.81	1.25	1	82.81	2	38.54
20	.82	78.34	1	2	18.52	2	77.42
21	1.46	106.84	1	3	24.67	2	
22	1.59	111.09	1	3	25.17	2	29.63
23	.36	53.57	1.75	1	50.41	2	76.04
24	.44	103.34	2	1	132.39	2	74.77
25	1.66	86.86	1	2	24.94	2	35.70
26	1.87	72.60	1.25	1	73.80	3	36.15
27	1.46	24.40	1	3	95.56	1	78.44
28	1.39	113.04	1	3	21.93	3	17.13
Average Median			1.41	1.89		2.25	

TABLE 38 CONT'D
NONTRADITIONAL ITEMS

		ADMINISTRATOR		BOARD		MEDICAL STAFF	
35	8	9	10	11	12	13	14
Question	W	FMD	Median	Median	FMD	Median	FMD
1	1.58	75.86	2	1	99.72	3	34.47
2	.58	64.53	1.50	1	86.55	2	47.05
3	.19	70.01	2	2	27.98	1	84.88
4	.44	65.66	2	1	73.47	2	80.87
5	.58	22.48	1.50	3	16.05	1	81.61
6	.44	80.43	2	1	97.06	2	74.38
7	.44	84.36	2	1	89.28	2	69.76
8	.44	79.37	2	1	84.89	2	75.37
9	.82	44.29	1.25	3	24.67	2	45.17
10	.02	33.31	1.75	2	14.98	1	58.75
11	.36	48.87	2	1	76.69	2	58.88
12	.11	71.48	2	2	15.71	1	72.37
13	.62	52.04	1.25	3	10.73	2	51.65
14	.95	34.64	1.25	3	31.79	1	72.14
15	.44	69.83	2	1	100.56	2	78.03
16	.19	50.99	2	1	56.67	1	75.12
17	.66	72.63	2	1	124.71	2	62.83
18	.48	62.38	1.75	1	98.33	2	71.13
19	.66	74.01	1	2	28.20	2	76.46
20	.44	81.53	2	1	127.23	2	87.19
21	.19	71.57	2	2	26.71	1	99.47
22	.44	79.64	2	1	97.10	2	82.82
23	1.92	32.64	1.25	3	27.01	1	85.83
24	.17	74.03	2	2	12.55	1	94.94
25	.19	64.07	2	1	58.48	2	60.71
26	.19	62.83	1.75	2	23.49	2	62.15
27	.44	82.82	2	1	91.27	2	91.10
28	1.00	97.84	2	3	26.01	2	72.58
29	1.18	108.12	1	3	21.49	3	37.83
30	.42	62.26	1.25	3	14.05	1	72.73
31	.53	69.08	2	1	105.55	2	66.81
32	.44	70.51	2	1	75.88	2	62.59
33	.66	43.71	2	2	17.02	1	74.80
34	.26	45.21	1.25	3	25.02	1	13.95
35	.46	72.12	2	2	16.62	1	94.48
Average Median			1.73	1.77		1.68	

was the average median greater than 2. In the remaining 17 items, the average response was less than 1.50. This indicates that, in most traditional areas, the administrator is expected to have the power to decide. In the remaining 11 cases he is expected to make recommendations.

In 26 of the 35 nontraditional items, the average median response was between 1.50 and 2 as reported in Table 38. In contrast to traditional areas, there is a greater likelihood that the administrator is expected only to have the power to make recommendations. In 9 instances he is expected to have the power to make a decision in nontraditional areas.

The average median response for all traditional area items is 1.41, and for all nontraditional items it is 1.73. Thus, the average median response for traditional areas is between 1 and 2, as predicted in Corollary One. However, the prediction in Corollary One that the average median response for nontraditional areas would be between 2 and 4 is not supported.

The data indicate that a higher degree of decision-making power is more likely to be part of the role expectations of the administrator's role in traditional areas than in non-traditional areas. On the other hand, the distinction made by the role senders between the normative degrees of decision-making power in both the traditional and nontraditional areas is not as great as was expected to occur. That is, the "range of tolerable behavior" is very small.[2]

It is possible that the different groups of role senders do make a clear and definite conceptual distinction between the two degrees of decision-making power, that is, between the power to make a decision and the power to make a recommendation. The existence of some overlap in the expected decision-making power in the two areas, and particularly in the nontraditional area, plus the lack of room for error in acting on one line of action rather than the other, could present the administrator with constant, potentially conflictful social situations. Indeed, the normative situation described above increases the likelihood that more serious violations of the norms would occur than if the role senders had made a greater degree of distinction between the expected degrees of decision-making power in the two areas - that is, if the range of tolerable behavior had been larger. In this context, an administrator who chose one line of action in an area (eg: made a decision), when the "others" in the situation expected him to choose the other line of action (eg: make a recommendation), would more seriously violate the norms than if there had been a greater separation in expected degrees of involvement as was predicted.[3] This assumes, of course, that greater degrees of involvement or power in decision-making by one group represents greater potential "costs and rewards" for each of the other groups. If this is true, then the distinction between making a decision and making a recommendation becomes an even more critical situation. Perrow has suggested that under conditions of "multiple leadership" this cost-reward situation does indeed hold true.[4]

While system actors may make a cognitive distinction between the two degrees of decision-making power, thereby increasing at least the cognitive clarity of the degrees of expected involvement, the overlap in expectations in either area suggests that clarity in behavioral cues would be very low. Given the "crisis" nature of hospital organizations, it is possible that if there were indeed a lack of role consensus in expectations - especially in nontraditional areas - that these conditions would constantly confront the administrator with potentially conflictful situations. He would then experience intra-role conflict in attempting to decide which line of action would be appropriate for an encumbent in his role, and would also experience inter-role conflict due to a lack of consensus among his role senders. Indeed, the condition of intra-role conflict would tend to arise out of conditions when inter-role conflict between members of the "management triangle" was most likely to occur.

As has been suggested by Everrett Johnson, and in the discussion in Chapter II, the administrator's role is expanding into nontraditional areas.[5] Johnson has also pointed out that nontraditional areas are less clearly defined than traditional areas. Thus, the administrator's role expansion into unclearly defined arenas of action should be instrumental in creating potentially conflictful situations under conditions of multiple leadership. Lack of clarity in the norms, hence the condition of potential role conflict, should be evident in a greater lack of role consensus. Furthermore, role consensus should be lower for non-traditional than traditional areas, as predicted in Corollary Two.

If the data support this prediction then the argument presented above should be supported. Lack of consensus in both areas would also lend support to the argument but not that of Everrett Johnson's.

Hypothesis Nine: Corollary Two

> The deviation from the median will be larger for traditional than for nontraditional.

Table 38, columns 2 and 9, report the deviation from the median frequencies (FMD) for each of the questions in the traditional and nontraditional areas. Consensus in traditional areas does tend to be higher than consensus in nontraditional areas, thereby providing some weak support for Corollary Two and the argument presented above. On the other hand, the degree of consensus among the four respondent groups is not particularly high in either area, although there appears to be somewhat higher and more stable degrees of consensus in traditional areas than in nontraditional areas. In the latter, the degree of consensus varies more widely. Due to the lack of role consensus, it would appear that while nontraditional areas could pose more serious conditions of norm violation on the part of the administrator, he is also likely to encounter similar difficulties in traditional areas, at least in some instances.

The administrator of Municipal Hospital perhaps best illustrates this type of problematic situation. As indicated in Chapter V, this hospital was in the middle of instituting changes in patient care practices at the time of the study. While the medical staff executive had resigned, purportedly because of the changes in the patient care practices, both the administrator and the nursing director felt the main issue was over "...who was running the hospital - the board or the medical staff."

Instigating and supporting changes in patient care practices clearly falls into what Johnson defines as nontraditional areas. At the same time, the board's decision to go ahead with the changes in nursing care technology, and the responsibility of the administrator to enact policy decisions of the board, suggest that traditional responsibilities and expectations of the administrator, and therefore his subsequent involvement in a nontraditional area of implementing changes in patient care, combined to create a conflictful situation for him. The history of the development of this situation perhaps best exemplifies the above statements. The Municipal administrator related the following events. The nursing director later confirmed this sequence as well.

> "Both the medical staff and administration had separately studied the system and the medical staff had agreed to go ahead. Now the hospital is planning to move the system from the surgical ward, where it was first introduced, to the medical ward. The medical staff had been asked for the acceptance of this move and had decided to defer this step. This first deferment had been accepted, but the medical staff had again recommended deferment and the board overruled them. ...I have my own opinions, but my ties are closer to the board because they are my superiors - organizationally. There's been some conflict over this with medical staff, or rather because of my closeness to the board."

The Municipal administrator was not alone in his conflicts with the medical staff over nontraditional aspects of the administrator's expanding role. As administrators increasingly come to make decisions or recommendations in areas affecting the functioning of medical staff within the hospital, the potential for conflict, and the development of mechanisms to balance the differences in power among the groups, is likely to increase. The administrator of Urban Hospital illustrated this in his "routinized" method of handling specific "known" areas of disagreements. In both instances, the fact that routinized means have emerged suggest, as Blumer put it in his 1971 presidential address, a history to an interactive episode. Urban administrator maintained an updated log of bed use by physicians "...as a preventive measure to use when they accuse me of interfering with their use of hospital facilities."

In the second case, he indicated that:

> "I maintain a listing of equipment costs and purchases, as well as the dates of purchase, to regulate requests for more funds. I especially have to watch this with my professional staff in X-ray. They're always coming to me and telling me I am interfering by restricting their equipment purchases. When they do, I can show them this record. Its pretty hard arguing with that because its pretty clear they get a large part of the budget. X-ray films and equipment are expensive. I've got to watch this or they would be in here all the time saying I am not fair with them."

Even the administrator of the pretest hospital ran into problems with physicians in areas affecting physicians' use of facilities for surgery. He indicated that he and the chief of staff checked into the complaints together and made recommendations to the medical advisory committee, in order to deal with his "...conflict with the medical staff."

Perrow has described the condition of multiple leadership as follows:

> It is different from fractionated power where several groups have small amounts of power in an unstable and

> temporary situation. With multiple leadership there are a small number - perhaps two or three - of recognized centers of power. It is different from a contest of power, for the groups do not seek - at least over the short run - to vanquish each other, but recognize each other's sphere of interests. Nor is it the same as decentralized authority, where specialized units have autonomy. In such a case units are free to operate as they choose only up to a point, when it becomes quite clear that there is a centralized authority. In multiple leadership there is no single ultimate authority in fact, even though there is in the official constitution.[6]

Given the evidence from other studies, and the delineation of the management triangle as a condition of multiple leadership, it would appear that the structural situation that confronts the administrator, as shown in the data presented, would stimulate some kind of coping or adaptive behavior on his part. James and Pierce have suggested that administrator behaviors vary from withdrawal or abdication, to "professionalism" or active leadership in all areas of hospital operation.[7] Indeed, in discussing the conditions that make it possible for multiple leadership to function, Perrow suggests the need for "...some kind of facilitating leadership, someone who keeps explosive issues from erupting too often and maintains easy, comfortable relations among the groups."[8] While it is not necessary that this "facilitating leadership" come from the administrator, in Perrow's study it did. On the other hand, given the kind of role expansion of the administrator today, and the changes being undergone by the hospital, these factors would appear to support the movement of the administrator into this kind of leadership role in nontraditional areas.

James and Pierce do not, however, indicate the type of structural conditions which tend to stimulate any of their six types of administrative behavior on the part of the administrator. The structural situation as discussed above, both with respect to the normative constraints as determined by the median response in each of the two areas, and the degree of consensus about the expectations as measured by the deviation from the median frequency, would appear to encourage active decision-making leadership on the part of the administrator in traditional areas, and a more accomodative, recommendation-giving stance in nontraditional areas. This would, of course, be compatible with conditions of multiple leadership and would also provide the structural supports pushing the administrator into a facilitating leadership role.

Having indicated that the lack of role consensus and the very small "range of tolerable behavior" creates a potentially conflictful social situation for the administrator, it would be desirable, at this point, to examine the expected degrees of involvement of the other two groups of the management triangle in traditional and nontraditional areas. Indeed, if the premise is valid that a role cannot be defined without reference to its counter-roles, that is, if the principles of reciprocity and complementarity are sociological laws, then the data concerning the administrator's counter-roles must be presented.

Furthermore, analysis of the data regarding board and medical staff involvement would help to determine if conditions of multiple leadership in fact prevail in this study. It would also provide an opportunity to test some of Perrow's conditions for multiple leadership.

If Perrow is correct, then one necessary condition for multiple leadership to exist is near equality of power of the three interest groups. Accordingly, board and medical staff involvement in decision-making should be expected to be high, since administrator involvement is also relatively high. In keeping with Everrett Johnson's argument, however, and indeed with the data presented earlier, the degree of expected involvement of the administrator in traditional areas should be higher than that of the board and the medical staff. Furthermore, Johnson has also argued that the expansion of the administrator's role to this point has been accomplished by absorbing functions from areas in which the board previously functioned. The degree of expected board member involvement should therefore be lower than the other two groups in traditional areas. Furthermore, the degree of consensus about board member involvement should also be more variable because of this process of role absorption. Medical staff involvement could be expected to be intermediate because of their continuing importance in the functioning of the organization, although not as primary leaders as was the case during the period of medical domination as discussed by Perrow.

In nontraditional areas, the power involvement of all three elements of the "troika" should also be relatively high and approximately equal, since it is in these areas that the "costs" of other groups' involvement is particularly high. This includes, as Perrow has pointed out, degrees of power involvement which do not rule out the involvement of any of the other groups in the triangle. This would occur if one group had decision-making powers in most of the decision areas, as does happen in traditional areas. Thus, there should be a tendency for each group to be expected to share power in nontraditional areas. This would be accomplished if each group was generally expected to make recommendations, but not decisions.

Perrow also indicates, however, that for the condition of multiple leadership to prevail, no group should be unified in its opposition of the other two. Accordingly, while consensus may be at a lower level for decision-making in nontraditional than traditional areas, it should be less variable. Greater variability would indicate that some opposition exists to the norms held by others.

Finally, Perrow suggests that areas of action may be demarcated for which one group has the right to make decisions, while the other groups are similarly accomodated but in different areas.

As can be seen in Table 38, the average median response for administrator involvement in traditional areas is lower than for either the medical staff or the board of trustees. This indicates that the administrator is more often expected to have the power to make decisions in traditional areas. While both the medical staff and the board of trustees' involvement is lower than the administrator's expected degree of involvement, the board and not the medical is intermediate in power, as was expected to occur.

The medical staff, in general, is expected to make recommendations, or may or may not become involved. The board, however, is more likely to be expected to make recommendations, while at times being expected to make decisions.

Comparison of the deviations from the median frequency for each of the three groups for traditional areas (columns 2, 5, 7 in Table 38) indicates greater variability in consensus for the board, as compared to consensus about the norms for involvement of either the administrator or the medical staff. This supports the argument presented earlier regarding role absorption of board member functions by the administrator. Furthermore, consensus about administrator involvement in traditional areas tends to be higher than for medical staff involvement. With respect to consensus about board involvement, it is apparent that consensus is greatest about the areas in which they are expected to make a decision (eg. joining a group purchasing plan, appointing a hospital administrator, deciding on insurance, determining budgets for a new fiscal year, or renovating existing plant facilities.) These represent areas of long term planning, whereas least consensus tends to revolve about areas of day-to-day activities which the administrator has taken over from the board. On the other hand, in those instances where the board is expected to make a decision, the administrator is expected to make recommendations, presumably to the board. As in most other organizations, these conditions make it possible for administrators to control the decisions of policy-makers who come to rely on the information and recommendations their appointed officers make to them.[9]

In fact, most of the administrators indicated the need to "...give leadership to the board," as the administrator of the pretest hospital put it. The Midland administrator stated most clearly what this meant in terms of administrator/ board relationships.

> "Another time consuming area for me is board activities. The textbook may give the outline, but board members must be trained. The hospital administrator must orient the board, and he must recommend to the board many of the things that become policy. This involves the use of board committees. The administrator generally initiates board activities and provides the data for the board to make a decision, which is the final authority."

In most cases, the recommendation and the data for the final decision to involve the hospital in shared facilities and long term planning come from the administrator and his management team. In the case of the Midland administrator, for example, the first interview was interrupted when he received a call from another administrator of a smaller regional hospital about sharing laboratory facilities. The administrator later indicated, in relating the substance of the offer, that the attempt to regionalize laboratory facilities was at his initiative, and that he had "...persuaded the board of its value." Even the administrators of Southern Municipal and Southern Religious, and their management teams, were directly involved in instituting the sharing of facilities between the two hospitals, although the boards in each case retained the authority to ratify decisions.

In this regard, it should be pointed out that while the decision-making power of the administrator is constrained to "recommendation-giving" this is not an inconsiderable source of influence.

The average median tends to be similar for each of the three groups for nontraditional areas, as shown in Table 38, columns 10, 11, and 13. The average median response for the administrator is 1.73, for the board 1.77, and for the medical staff 1.68. This indicates that the decision-making powers of the three groups are approximately equal and tend towards recommendation giving powers, although the medical staff is somewhat more likely to be expected to make decisions in nontraditional areas. This data supports Perrow's observations about the conditions necessary to support multiple leadership.

The consensus about medical staff involvement is somewhat higher in most instances than it is for administrator involvement. (Compare columns 9 and 14 of Table 38). For both groups, consensus tends to be relatively stable, while for the board consensus is more variable, suggesting some opposition to the degree of decision-making power expected of the board (Column 12, Table 38).

The medical staff appears to be expected to make decisions in areas relating directly to the provision of health and patient care, while the other two groups are generally only expected to make recommendations. There is also high consensus in these areas about medical staff participation. These areas include such things as dealing with problems in clinical departments and outpatient services, as well as with the use of medical resource material.

This latter finding lends support to Becker and Gordon's argument that the users of resource materials - the medical staff - and not the owners or their elected representative -

the board and the administrator - specify the procedures for the organization. This situation produces a truncated bureaucracy to which another organization is "internally coupled."[10] In the case of the hospital this is the staff organizations, or as Mary Goss appropriately defines it, the advisory bureaucracy.[11]

In this regard, the data indicate that the medical staff is also allocated decision-making power in areas affecting the medical staff organization. This is not an unexpected finding. On the other hand, administrators are allocated the power to make recommendations to the medical staff about their organization. This clearly supports Everrett Johnson's argument, and suggests as well that the administrator is expected to function in a "facilitating" role in this area. This situation also indicates that the administrator has an opportunity to influence functional matters by working through the staff organization. As has been suggested earlier, however, the administrator may abdicate this area or may attempt to provide leadership. Which of these behaviors are engaged in by the administrators in this study, and what the consequences are in either case, remain to be seen. It is clear, however, that the normative structure supports the movement of the administrator into an accomodative leadership position.

The areas of concern for which the board of trustees is expected to make decisions, and for which there is high consensus, revolve around committing the institution to shared facilities, determining what health needs the institution should attempt to meet, and the appointment of people such as the assistant directors of nursing or medical services.

There is high consensus about administrator decision-making involving day-to-day problems such as the disposal of wastes from laboratory and medical procedures, conflicts between medical staff and hospital personnel, and physicians' noncompliance with hospital regulations. In comparison with the other two groups, the administrator tends to be expected to make fewer decisions in nontraditional than traditional areas, while being expected, however, to make recommendations to the other two groups. This would suggest that the administrator is expected to provide the operative administrative link, or what Perrow calls "facilitating leadership," between the policy making body and the technical body which directs and performs much of the immediate work of the organization. Both of these groups tend to have more decision-making powers in nontraditional areas as compared to the administrator, who must link both groups through recommendation giving powers.

Hypothesis Ten

> The median response of the board of trustees to nontraditional areas of administrator responsibility will be lower than the median responses of the medical staff.

Hypothesis Ten is directed, in part, by Hanson's concern with the systemic linkage hypothesis and role consensus patterns in hospitals,[12] as well as by Johnson's argument that board members are more likely than medical staff members to support expansion of the administrator's role into nontraditional areas. Indeed, the concerns of both Hanson and Johnson are very similar in that the systemic linkage between the administrator and the board is generally felt to be much stronger than the linkage between the administrator and the medical staff.

Hanson quotes Charles P. Loomis in defining systemic linkage "...as the process whereby the elements of the two social systems come to be articulated so that in some ways they function as a unitary system."[13] Hanson goes on to say that:

> In this case, the position itself is viewed as the nexus or link between two systems. It is because encumbents of counter-positions in a given system hold positions that link (and obligate) them to different other systems that systematic differences can be expected between groups who respond to the same set of role expectation items.[14]

Johnson has argued that not only are administrators more closely linked to the board of trustees through administrative and legal channels, but that the board's changing and declining involvement in the day-to-day operation of the hospital increases their propensity to support the administrator's role expansion into matters involving medical care and medical staff organization. Johnson's argument on this point is summarized in his essay. He states that:

> The seeds of change are already sprouting. Research in the area of trustee expectations for the ideal hospital administrator has shown their desire for expanding the administrator's role. This work pointed out that trustees expect greater leadership from the administrator than do the medical staff or hospital staff. This means that the trustees will encourage rapid expansion of administrator activities, because they believe he should be, or they actually do hold him, accountable for all hospital activities, including the administrative affairs of the medical staff. Trustees believe that the effective administrator is one who is concerned with all affairs of the hospital. Conversely, they believe an ineffective administrator is one who limits himself only to internal hospital staff activities.

> This expectation by trustees is a carry-over from their own experiences in business activities. In general, the chief executive officer of a business is held accountable by his board of directors for all the affairs of that corporation. As hospitals and businesses become more complex, it is reasonable to believe trustees will transfer the concept of total accountability from one sphere to the other. Their ability to discriminate between medical staff-administrative functions, and internal-external hospital affairs, will lessen as these activities become more complex and inter-mingled.[15]

While the quality of care remains the legal responsibility of the board, their involvement lies primarily at the policy-making level. Furthermore, hospital boards are increasingly coming to rely on administrators trained in hospital administration, who can be expected to deal with the complex business of providing health care through an organizational form that is becoming the nexus of the health care system in North America. This, plus the trend for administrators to be held legally responsible for the quality of medical care provided, are further reasons why boards could be expected to support higher involvement of the administrator in non-traditional areas.

Table 39, columns 1 and 2, reports the combined medians and the Chi Square values for the board and medical staff rankings of administrator involvement. There is considerable agreement between the medical staff and the board of trustees on traditional items. In only two instances are there any significant differences between the board and the medical staff in their ranking of administrator involvement in traditional areas. The members of the board of trustees are more likely to expect the administrator to make a decision about admission practices and about resolving conflict between

TABLE 39
BOARD AND MEDICAL STAFF AGREEMENT ON ROLES CONCEPTION ITEMS FOR ADMINISTRATOR RESPONSIBILITY IN TRADITIONAL AND NONTRADITIONAL AREAS

TRADITIONAL			NONTRADITIONAL		
	Column Number			Column Number	
	1	2		3	4
Question Number	Combined Median	Chi Square	Question Number	Combined Median	Chi Square
1	2		1	2	.467687
2	2	.211931	2	2	4.41712*
3	2	4.80165*	3	2	20.2189*
4	1		4	2	2.23315
5	2	.719577	5	2	4.96583
6	3	.187848	6	2	1.91667
7	1		7	2	.22016
8	1		8	2	1.45714
9	2	.425806	9	2	3.62069
10	2	1.72767	10	2	1.51843
11	2	2.94785	11	2	3.18009
12	1		12	2	2.08913
13	1		13	2	2.95455
14	1		14	2	2.78913
15	1		15	2	4.19717*
16	2	.435203	16	2	.331579
17	1		17	2	.552323
18	1		18	2	4.05333*
19	1		19	2	
20	1		20	2	1.8059
21	1		21	2	.14899
22	1		22	2	1.91837
23	1		23	2	1.54337
24	2		24	2	.426748
25	1		25	2	1.08189
26	1		26	2	1.16667
27	2	7.06117*	27	2	1.42774
28	1		28	1	
			29	1	
			30	2	2.88505
			31	2	.16369
			32	2	.301339
			33	2	5.77441*
			34	2	5.18211*
			35	2	3.24807

*X^2 significant at .05 level. Blanks indicate chi square cannot be calculated, question numbers correspond to items in table.

heads of clinical departments, than are the medical staff.

The data directly relevant to Hypothesis Ten are reported in columns 3 and 4 in Table 39 . In contrast to traditional areas, administrators are generally expected to make recommendations, as the combined medians clearly indicate. Furthermore, there is some support for Hypothesis Ten, since in seven of the items medical staff are more likely to expect less involvement than even recommendation giving on the part of the administrator, while board members are more likely to expect higher degrees of decision-making involvement.

It would appear that Johnson's argument has some support. The administrator's expected degree of involvement in non-traditional areas appears to lie more at an accommodative level (i.e. recommendation giving), than at a decision-making, directive level as is the case for traditional areas. The fact that the medical staff does expect the administrator at least to make recommendations in these areas does indicate a fairly high level of acceptance of him. This may, of course, be due to the type of working relations the administrators in this particular sample have developed with their medical staff. Indeed, the interview data support the "good working relations" explanation in most of the hospitals. This is especially true of the administrators in Urban, Midland and Southern Religious, as will be shown below. Another explanation is possible, however, and may in fact support and make possible the development of good working relations between administrators and their medical staffs.

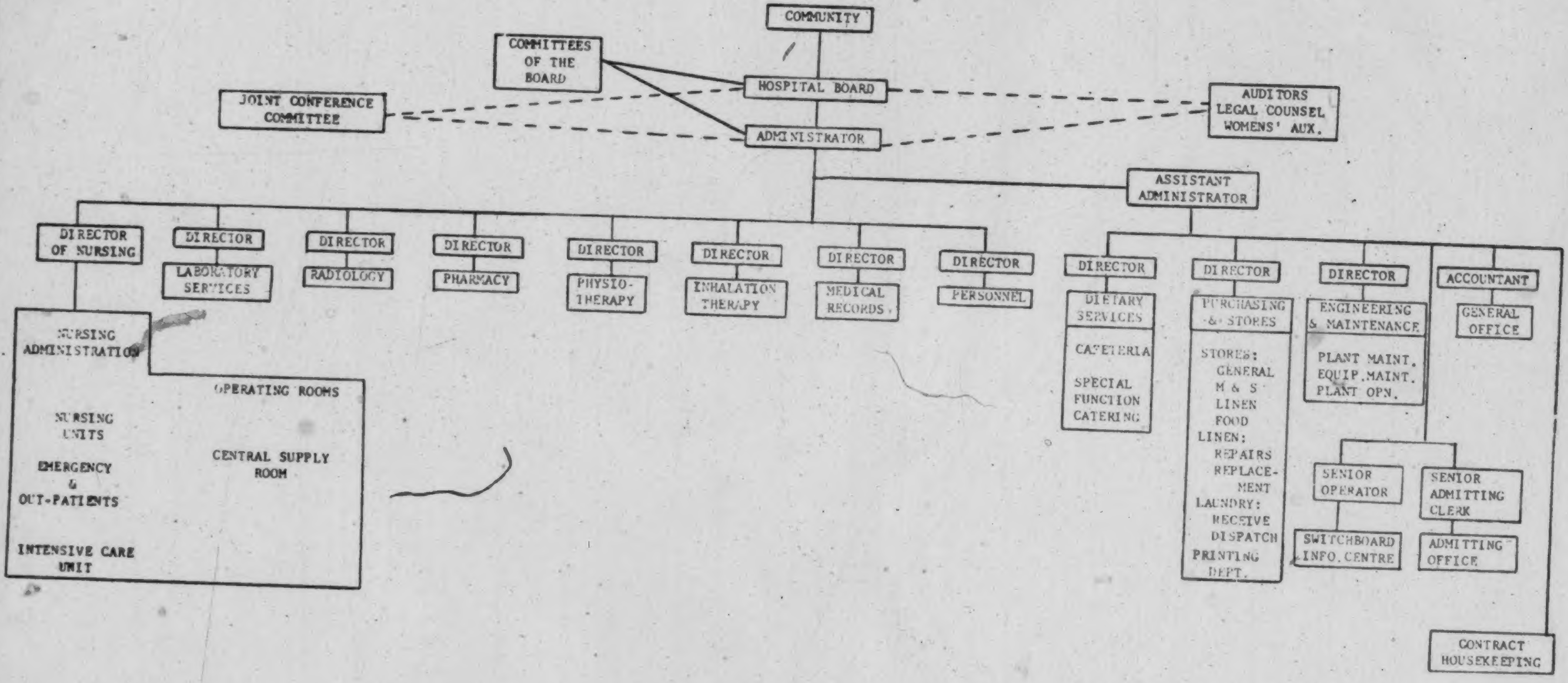
This argument rests on the historical development of the administrator's role. The administrator at the turn of the century was essentially a business manager, if not an accountant. The growing importance of the hospital as a health center, the rapid increase in complexity and cost of operation of hospitals, the increasing dependence of the physician on the hospital to practice, and the increasing levels of training and professionalization of the administrator, are factors which have pushed the administrator into increasing involvement in non-traditional areas.[16] These same factors, in turn, should also help increase acceptance of the administrator by the medical staff.

Most of the administrators when interviewed did suggest that the historical conditions surrounding their role contributed to their increasing involvement with the medical staff. Indeed, in nearly all cases, the organizational charts of the small hospitals had been recently reworked, assigning the administrator direct responsibility over clinical and nursing care departments, while business and plant functions were assigned to the assistant administrator. The organizational chart of the pretest hospital illustrates this division of labour. This chart is reproduced below in Figure 4.

Johnson points out that the work of the medical staff is a further factor supporting administrator involvement. He states that:

> There is an increasing recognition of the fact that medical staff work in the United States has two basic components: one, for the clinical direction of medical care in the hospital, and two, to handle the administrative aspects of the physician's work as part of the larger group of physicians. For example, the administrative work of the medical staff is carried on by the

FIGURE FOUR
ORGANIZATIONAL CHART ILLUSTRATING
REORGANIZATION OF TASK AREAS AMONG
ADMINISTRATION STAFF IN A SMALL HOSPITAL



> use of a committee structure. In large hospitals it is not unusual to find a meeting of a committee of the medical staff every week-day of the year.
>
> The problems of writing minutes, transmitting recommendations, and following through on committee decisions are done by administrators of hospitals. Frequent failure of physicians to attend committee meetings, to prepare properly as the chairman, or to report necessary decisions to higher committees, have placed the hospital administrator in the gap. With an increasing number of decisions being made by the medical staff, the committee method of making decisions is experiencing greater and greater difficulties.[17]

While these general trends have tended to support the movement of the administrator into non-traditional areas, none of the respondents indicated that it automatically increased medical staff acceptance of the administrator. All emphasized the fact that such support had to be gained. The Urban administrator illustrated this process by reviewing an event that had occurred shortly after taking up his position. In this instance he had supported the demands of the medical staff regarding a residency program. In providing that support, however, he had insisted that certain conditions be met that he felt were necessary to maintain good patient care.

This illustration serves to point out the exchange relationship that becomes necessary in the development of "workable" inter-relationships between the administrator and the medical staff. It also serves to highlight Bucher's condition for negotiation as a process. She states that:

> "It should be added, though, that this interaction can properly be called negotiation because what is at issue is not just what will be given to the faculty member, but what he is to give in return."[18]

It should be pointed out, as well, that the administrator, in exchanging his support for the support of the medical staff, did not entirely accede to their demands. His support was contingent upon assurances of maintaining quality "patient care." This same administrator indicated that these interests were also a means to control others. For example, he stated:

> "The overall goal of the organization is for the welfare of society's members, and this is a means to control situations and people. With some people you have to ask them to do something in the interests of the organization, even if it means that person has to change."

Support of the medical staff was not gained by providing them with whatever they wanted, but by establishing boundaries on the exchange. These boundaries were based on certain standards established and negotiated for by the administrator. Interestingly, this case is similar to the behavior of the administrator in Perrow's case study.

Instances like this, and some not so successful, also suggest the relevance of the administrator's "assessed stature." As has been indicated from the analysis of the data above, the administrator is expected to give recommendations to both the medical staff and the board, thereby widening his role-set. Contrary to Bucher's insistence that organizational factors are unimportant, it is clear that these expectations are attached to a particular position at a particular level in the organization. At the same time, however, while the organizational position opens up alternative lines of action which make possible the development of a high assessed stature, these lines of action may not be used by a role encumbent, because, in James and Pierce's words, he may abdicate his responsibilities in these areas. It is also possible that a role encumbent may attempt to use the lines of action open to him, but fails to maintain a balance of power through identifying with one group more than with the other, thereby alienating the latter, as was the case with the Southern Municipal administrator.

In the case of the Urban administrator described above, involvement with the board in the medical staff organization increased the size of his role-set. At the same time, however, the ability of the administrator, and the "facilitating role" he played between the board and the medical staff served to increase his assessed stature. Much the same situation was reported in Midland Hospital where the administrator was "highly respected" and considered a near peer by the medical staff because of his involvement in and knowledge about the medical staff organization. In Municipal, however, the administrator's loyalty to the board appeared to have a negative effect on the medical staff's assessed stature of him, and on it's cooperation with either the board or the administrator.

Thus, the process of conditional negotiation would appear to be a first step in developing "good working relations" with the medical staff. Such negotiated interpersonal structures, however, are never stable, as all the administrators emphasized. They are capable of deteriorating rapidly in the face of extreme conflict and without adequate mechanisms to handle potentially "red hot issues," as Midland administrator put it. Furthermore, such structures become possible at this level when conditions of near power equivalence can be maintained.

The administrators of Urban and Midland illustrated this point by reviewing past conflicts with the medical staff. To both administrators, these conflicts represented potential threats to their jobs. Both emphasized the fact that their respective boards had supported them in their actions. The structure of multiple leadership would appear, from these two events, to be highly dependent on the exchange of support among the different groups of the triangle. Indeed, some analysts of the triangle have indicated that board/administrator relationships are likely to be the strongest, in terms of loyalty, of the three possible arms of the triangle.[19] As suggested above, however, this potential strength and loyalty may be a weakness and threat to the balance of power within the management triangle. Furthermore, as Rothman has shown, the medical staff and its organization are capable of strong and persistent resistance, and may be the strongest politically of the three groups.[20]

At the same time, however, the administrator must function on a daily basis with the medical staff while having to implement board policy, and depend on the board to support him in any conflict he has with the medical staff over policy. This was illustrated in the case of the administrator of Southern Municipal. In following traditional lines of authority in implementing board policy, he ran into conflict with the medical staff over implementing a policy that involved the administration. As indicated by the data, while the administrator is expected to make decisions in some areas, in others he is only expected to make recommendations. With this kind of contingent power he must maintain a balance in the different spheres (and bases!) of power and thereby provide "facilitating leadership," influencing both the board and the medical staff through his "assessed stature." Indeed, Johnson's comments that the board is most likely to support, and indeed push, the administrator into non-traditional areas finds some support in this instance.

Indeed, all the administrators mentioned instances where they made recommendations to the chief of staff which they expected to be implemented by the medical staff. As indicated in Chapter V, the Midland administrator most clearly exemplified the use of the staff organization as a means to "...influence patient care." But all the other administrators related much the same type of "organization set" relative to influencing or recommending decisions among the medical staff. For example, the administrator of Southern Religious indicated this in stating:

> "I talk to the chief of staff or the president and they take the matter from there....I rely on someone who has an interest in a particular area to express my concerns to the medical staff."

The assessed stature of the administrator, and hence his ability to function in a facilitating role, is partly dependent on how well he handles his relationships with the other two groups. It is no wonder that D'Amours and Gordon both conclude that the greatest weight is put on the weakest link of the management triangle.[21]

II. THE ADMINISTRATIVE PROCESSES

This part of the chapter will discuss general administrative processes, based primarily on the interview material, rather than focusing on each hospital and administrator separately. The primary focus on general patterns reflects the considerable similarity in administrative structures and processes that were found to exist across hospitals in a content analysis of the interviews. Where differences occured, they tended to be an exaggeration of the general patterns, as was the case with the Midland administrator and his high involvement with the medical staff. In some cases, these exaggerated instances made the underlying administrative structures in the other hospitals - and hence the general patterns - more apparent. Another reason for focusing on general patterns at this point is that most of the unique differences among administrators were discussed earlier in Chapter V.

James and Pierce have presented an analysis of their interview data on the administrative process in hospitals, and have discussed the organization of their data around six variables.[22] From these six variables they derived six types of administrative processes. The six variables which they felt best summarized their data, included the general status of the administrator, his relationships with the board, and also with the medical staff. Also included were delegation and control of authority by the administrator, the objectives of the administrative process, and finally, the coordinative area of the administrator's power and power relationships.

While many of James and Pierce's variables were used in organizing the analysis of the interviews for this study, it became apparent that other factors should be included. Specifically, a more detailed breakdown of the control category appeared to be necessary and desirable in order to include such things as general technique, delegation and organizational structure, the use of committees, reports, policy, procedures, and rules. In addition, the relationships among the management triangle were included as a further factor in the administrative process, and which, for some reason, James and Pierce neglected to include. In some cases, the historical development surrounding the administrator in his role helped to clarify the administrative process practiced by each of the administrators, and where they each seemed to be headed.

Management Interrelationships

The administrator is directly responsible to the board, for whom he is their agent in the daily operation of the hospital and the implementation of the policy. In turn, administrative assistants and department heads are held responsible to the administrator. The medical staff, while representing the interests of the patient, are also responsible to the board of trustees. According to organizational theory, then, the board is that body responsible for the operation of the hospital. Administrative authority is delegated to the administrator, while privileges to practice on hospital premises are granted to physicians. This granting of hospital privileges is based on the physician's externally derived functional authority. While the physician derives his authority from other sources, he "...cannot exercise his authority upon the premises of the hospital except with the permission of the governing body of the hospital."[23] The privilege is subject to the bylaws and regulations of the medical staff. Thus, both the administrator and the medical staff are held accountable to the board.

Board/administrator relationships. In all instances, the respondents felt that the board/administrator relationships were good. This usually was a description of the administrator's overall relationship with the board, since two administrators noted that some individual members of the board presented difficulties at times.

For example, the Urban administrator indicated that:

> "I've had to deal with some board members over the years who kept getting involved in my activities. I usually dealt with them personally in direct confrontation, and the board in general supports the policy that they don't get involved. So I can handle them that way - and show them they are breaking board policy!"

Later, Urban administrator indicated that he had been instrumental in establishing the board policy that the board was not to become involved in day-to-day activities.

The Municipal administrator also indicated that he had "...no problems with the board collectively. Some individual problems but I can handle them through the board usually."

Two aspects of board/administrator relationships stood out in the interviews. One aspect was the establishment of boundaries around areas of action for the two groups. The second related to the interdependency of the relationship.

The first aspect stands out most clearly in the interviews of two of the administrators who reviewed the development of their personal roles. The Midland administrator insisted that, as one aspect of control:

> "...it is important there be a definite understanding between the board and the administrator. The board is like a legislative body and the administrator is like an executive who enforces policies and carries out the objectives of the board and the day-to-day care of the institution. The board does not and should not interfere in my decision-making. Conversely, the administration does not interfere with the board's responsibilities."

The Urban administrator pointed out that when he first took up his position, the board was "...a managing board - getting into the making of decisions. THAT had to change!"

Three administrators referred to the fact that board/administrator relationships and responsibilities were formalized in the hospital by-laws, and that both powers and responsibilities delegated to the administrator and board were specified. One policy accepted by the board was that they did not accept requests without first going through the administrator. As Urban administrator put it most clearly:

> "When I first came here there were no policies for anyone, so I got a committee of assistant directors together and told them to write up policy for their areas. I got the loan of a policy manual and showed them how to set up policy. The policy statement [illegible]mes to me, then it's sent to the board for their approval and then back to the persons responsible for it to be sent out. I also laid it to the board that they must set up policies delegating me my powers, and for the board as well, and one is that the board has accepted the policy that they do not accept requests without going through me first."

In this respect, it has already been shown that the Midland administrator felt that the board "...must be trained," and that he "...initiates board activities and provides data for the board to make a decision, although the board is the legal, final authority." Urban administrator also emphasized the need to provide "...leadership to the board on long-range planning," and that he uses his "...good relations with the board to help influence policy." Most counter-role administrative assistants also pointed out this aspect of board/administrator interdependency. For instance, the finance director of Southern Religious summarized what most of the assistants said in describing his administrator. He stated that:

> "The board listens pretty carefully to------advice. They respect------opinion and most often follow the direction that is laid out for them.------is pretty careful about this and makes sure that the information and policy recommendations are straightforward, well documented, and understood."

That is not to say that the influence is entirely one way. In one observed instance, the chairman of the board, the administrator, and the observer were waiting to have lunch. The chairman and the administrator were discussing some general topic when the board agenda was raised. The ensuing, and brief, discussion resulted in the administrator's agreement to include an agenda item in which the chairman was interested, while the chairman agreed to a change in the order in which agenda items were to be discussed. The implication was, of course, that the agenda items moved to the last part of the agenda would be passed over quickly, or not discussed at all. The previous topic of discussion was then continued. Again, Bucher's typification of negotiation is applicable to this interaction. It should be noted, however, that often such interpersonal negotiations have direct consequences for collective negotiation in other arenas of actions - in this case the board meeting.

One other ramification of the board/administrator relationship should be noted. In Southern Municipal Hospital, the administrator maintained that his ties with the board were very close. As a result of this, some resentment and conflict with the medical staff tended to ensue. Thus, the organizationally prescribed and informally developed relationships between board and administrator can have systemic consequences for board/medical staff and administrator/medical staff relationships.

It is possible that the "politicalism" type of administrative process described by James and Pierce - intimate and informal with much influence between board and administrator - may have the potential of creating administrator/medical staff conflict. The "in-group" type of administrative process, whereby relationships between the administrator and the board are "well defined and formal with obvious respect and recognition," may decrease the potential conflict with the medical staff, at least concerning decisions made on the grounds of loyalty.

As discussed earlier, the administrator must attempt to maintain a balance of power in the management triangle, with less than absolute decision-making powers. At the same time, however, the board is his main source of support in any conflicts he has with the medical staff. While this mutual support may help restore a nearly equivalent power relationship during periods of conflict, it would appear that the board/administrator relationship must be carefully managed so as not to create the feeling among the medical staff that their concerns have not been given proper consideration. Otherwise, the medical staff/administrator relationship may be disrupted due to the lack of perceived role distance between the board and administrator. This may, in fact, be a consideration in the staff's assessed stature of the administrator, and in the corresponding willingness to accept or not accept his recommendations - this being the only major decision-making power that he has in nontraditional areas, as the data presented earlier clearly showed. Of course, the balance of power can be disrupted as well when the board is "...more oriented towards the medical staff than the last one," causing some difficulties for the Municipal administrator in this situation.

The data is not sufficient to test these considerations adequately, but research into the management triangle in the future should explore the possible effects of this type of administrative process on the management interrelationships at this level in the organization.

Medical staff/administrator relationships.

> "A nonmedical administrator has to gain the confidence of the medical staff and show them he is valuable. You can't come in and throw your weight around. Physicians are independent contractors with no line controls, even though they create most of the costs. I use the medical staff organization to maneuvre better patient care - but I don't try to tell them what to do clinic-wise. I work with the Medical Advisory Committee and through the chief of staff. The MAC is the place to discuss emotional matters rationally."

This interview with the Midland administrator represents the general consensus, and most of the points, made by the administrators of all the hospitals regarding their relationships with the medical staff. The need to "manage" relationships with the medical staff has been discussed earlier in this chapter. The type and quality of those relationships, however, have not been discussed.

It is apparent in the above quote, and in the other interviews, that Bucher's concept of assessed stature is as relevant to the general hospital as it is in the medical school. While the administrator's assessed stature with the board rested on criteria relevant to management practices, it is clear that functional criteria were relevant to the medical staff. Indeed the administrator/medical staff relationships appeared to depend on the quality of patient and nursing care practices. At the same time, while the administrators in the hospitals held ex officio offices on many of the staff committees, their continued participation in the Medical Advisory Committee (MAC), their knowledge about medical staff organization, and their working through the chief of staff appeared to be the main factors affecting the staff's assessed stature of the administrator. In turn, the organizational position of the administrator, vis-a-vis his decision-making or recommendation giving powers, also appeared to be influential in affecting its use of the formalized channels, and thereby indirectly, its assessment of his stature.

In the case of the Midland administrator quoted above, he felt that the staff saw him as part of the medical staff organization due to his attendance at their meetings. The review of Midland Hospital and its administrator in Chapter V indicated that his counter role assistants concurred with this appraisal. They also added that the lack of a medical director forced him to work very closely with the medical staff, and that he spent a very large amount of his time on matters pertaining to the medical staff. They generally felt that his knowledge about the medical staff by-laws and organization was very high and that this increased the respect the medical staff had for him.

The administrator's relationships with the medical staff of Southern Municipal had been strained, but subsequent interviews later indicated that the intensity of this conflict had been reduced. Some strain was still evident, however, and was attributed to the continuing conflict over "who runs the hospital."

In the remaining cases, medical staff/administrator relationships were characterized as good, and attributed to the administrator's knowledge about staff organization and functioning, conditional support for medical staff concerns, and attendance at the Medical Advisory Committee meetings. Their use of these meetings as places to "...plant ideas and let them germinate in the Medical Advisory Committee" is consonant with the pattern observed in Midland Hospital and also in the pre-test hospital.

A second point, of which there appears to be two facets, relates directly to the medical staff organization. That is, the medical staff members were viewed as autonomous or independent practitioners. In this regard, Urban administrator indicated that:

"They are a nonsalaried occupational group. They're

> free lance entrepreneurs and I have little control over them. However, there are negotiable points, beginning with the staff organization itself, the Royal College of Physicians and Surgeons, the Medical Academy and the hospital association."

This, plus the fact that their relative autonomy was functionally based, created control problems for the administrators. Nevertheless, in all instances the medical staff organization and its formal hierarchy was used or appeared to be used as an indirect means of influence by the administrator.

As indicated above, the Midland administrator indicated that he "...work(s) with the Medical Advisory Committee and through the Chief of Staff." The Urban administrator directed many of his concerns through his medical director, but also suggested that: "I have an ex officio position on medical committees and they are a good forum for discussing differences. They serve as a clearing house." The administrator of Southern Religious also indicated that: "I always attend the Medical Advisory Committee meetings. I also attend the infection, nursing, and drug committees. The medical committees are valuable, and I think the medical staff appreciate my attending them."

This aspect goes beyond the formal responsibility of the administrator for maintaining a functioning medical staff organization. That is, as Taylor has pointed out:

> He must see that the staff sets up a suitable organization and he must back up the medical staff in the necessary enforcement of their own bylaws because the medical staff bylaws are an extension of the hospital bylaws: they represent a delegation of board authority for the conduct of staff work so that it is the administrator's responsibility to see that this board responsibility is properly assumed.[24]

By ensuring that a formal medical staff hierarchy exists, the administrator also ensures for himself that points of contact with the medical staff are maintained through which influence can be exercised. The points of contact are through the chief of staff, to whom the administrator can direct complaints about patient care, set in operation the investigation of nurse-physician conflict, and impart information and ideas with the expectation that a two step flow of influence will operate. The administrator of Southern Religious, for example, stated that:

> "It is necessary to see that the medical staff organization is functioning in order to use the bylaws to ensure good patient care. It is my responsibility, as well, to see that the committees are functioning and the bylaws updated. The steps I take to get something initiated are through the chief of staff. I talk to the chief of staff or the president - or I go to a clinic head about a problem. If a recommendation is accepted it goes to the MAC. I rely on someone who has an interest in a particular area [illegible] get recommendations made. My main contact with the medical staff is through the chief of staff - should always go through him first."

While Midland administrator followed the same route, as indicated in the quote introducing this section, the Southern Municipal administrator differed somewhat. His main contact was the president of the staff.

> "The president is really working to keep cooperation now. They (the medical staff) respect him. For example, we've managed to get a delineation of privileges set up. Previously there was a real battle here two to three years before we introduced the new nursing techniques."

Regarding the administrator's responsibility towards ensuring that the medical staff organization was functioning, the Municipal administrator recognized the responsibility but indicated that:

> "These people are autonomous, although the staff organ-

> ization helps ensure higher quality of care. If there are problems with the staff organization, you have to indicate this weakness through the medical hierarchy."

Taylor hints at this pattern when he states that:

> The chief of staff has direct authority from the Board to carry out supervision of clinical work, but in the actual performance of that duty he must use an administrative instrumentality. The Board's chief executive officer in the hospital is the hospital administrator. No direct nor indirect powers granted by the Board to any others are intended, nor should they be permitted to be exercised otherwise than through the authorized administrative authority. To say that the chief of Staff's authority is direct, therefore, does not indicate that the chief of staff may have powers parallel to or in opposition to those of the administrator. The chief's clinical judgement is used in his supervision but his authority for "control of clinical work" requires an administrative act and the authority for all hospital administrative function is vested in the administrator.[25]

Similarly, the Medical Advisory Committee is seen, as the administrator of the pretest hospital put it, as a "... political body as it can influence policy," and is a forum for the administrator to report to the medical staff certain administrative concerns, board policy and the reasons for policy. It serves, as the administrator of Southern Religious put it, "...a clarification function and a place for medical staff to also express their concerns."

The essential distinctions between administrative and functional authority regarding the medical staff that Goss has identified, are merged not only through a medical staff position which blends professional with administrative authority within the medical staff organization, but in a formal hierarchy and committee structure that have similar functions. In this way, the presumed conflict between administrative and professional concerns can be dealt with to some degree. The "advisory bureaucracy," then, can be used by the administrator as well by ensuring that a formal organization is functioning. While Goss examined the advisory bureaucracy from the point of view of the professional's adjustment to bureaucracy, the discussion here implies that such a structure can be used by the administration as a means of adjustment to "professional autonomy." This depends, of course, on the willingness of the two bodies to cooperate. A breakdown at the chief of staff-administrator level leaves little leverage for the administrator. Maintenance of the link appears to be dependent on the staff's assessed stature of the administrator.

Explicit recognition of the advisory bureaucracy was illustrated by the Midland administrator who stated that:

> "The medical staff doesn't hold to the line principle that is found in hospital administration. They do go to their senior members of the medical staff for advice and consultation. If a medical staff person wants facilities, they may use the MAC, which is the political arm of the medical staff..."

While administrators may cope with professional autonomy by using a formal structure to "maneuvre" with, in one instance a respected member of the medical staff also served as "sounding board" and "devil's advocate" for the administrator. This administrator/physician relationship in Urban Hospital, however, developed over time.

> "I found that he had withdrawn because of no administrative support, and was overlooked by the medical staff because of his youth. I got him what he needed and I got a supporter at the staff level. I also got support from another physician and he brought with him people who he controlled."

It is therefore possible for the administrator to utilize the advisory bureaucracy in an informal manner, but the preferred mechanism appears to be through a formal structure which is not expected to function entirely like a formal structure.

Although the formal staff organization is a mechanism by which the administrator can maintain contact and influence with the medical staff, the administrator/medical staff relationship is also contingent on standards of care. In relating back to a question on control, the administrator of the pretest hospital remarked that:

> "Control is care. The medical staff/administrator relationship depends on the quality of care and patient services. If these don't meet the needs of the medical staff or they are unsatisfied with the services, then they are unhappy."

Changes in nursing care and patient care practices in two instances, Midland and Southern Municipal, and in a related manner, the apparent encroachment of the nurse on physician in a third instance in Urban Hospital, all had at some point strained administrator/medical staff relationships. In Municipal changes in patient care practices had system wide consequences. Interestingly, the staff organization was not considered viable at the time the conflict arose in this organization. As noted in Chapter V, the changes in patient care practices in Midland had become institutionalized by the time of this study, and had been directed by the strong nursing director in that hospital. Despite the nurse-physician conflict at the time changes were instituted, this organization showed no signs of a continuing conflict as was the case in Southern Municipal.

Board/medical staff/administrator relationships. In most instances, this relationship among the triumvirate is mediated through the Joint Conference Committee and the role of the administrator. In part referring to the system wide structure of committees, but also referring to the triumvirate relationship, the administrator of Urban Hospital stated that: "I don't live in a rose colored world you know. I live in a world of conflict - but minor conflict that is handled through committees and setting up opportunities to work out differences." The J.C.C represents another formal mechanism by which potential conflict between the administrative body and the professional body of the organization can be contained.

Thompson, in his discussion on committee structures and functions, refers to two types of committee structures whereby either the means to an end, or the causes of a problem are sources of conflict for participating committee members.[26] Conflict, he points out, is inherent in organizations and committees when the members bring different points of view to bear on a problem. Interestingly, this is very similar to Strauss's depiction of professional organizations and the processes of negotiation.

While the Joint Conference Committee does not make decisions - a point emphasized by all interviewees - it is an arena in which the differences in orientation among the participating groups are or can be discussed. Further functions were referred to by the Midland administrator in describing it as a

> "...safety valve. A red hot issue can be referred to the J.C.C. and allow for the crystallization of ideas. It is not an action committee. Any other use and both the board and the medical staff will not legitimate its decisions."

The Urban administrator stated that:

> "It is a liason committee between the board and the medical staff, not an action committee. It is to provide a free exchange of thought and ideas between the medical staff and the board. The minutes from the J.C.C. go to the M.A.C. and to the board as a whole."

In all the hospitals but one, bimonthly meetings were scheduled for the J.C.C. Recommendations were sent from this body to both the medical staff and the board for further deliberation and action if that was felt to be necessary. In one case, the J.C.C. was called "...only when necessary," and no recommendations were sent from the committee. It was in this organization, Southern Municipal, that a system wide conflict developed, resulting in the resignation of the executive body of the medical staff. In this hospital, the J.C.C. met a number of times to deal with the conflict that was developing, or rather which had developed, over changes in nursing care practices.

While no cause-effect relationship is implied here, the J.C.C. does seem to function as one means by which administrative and functional concerns can be accomodated. This appears to be best done by "routinizing" the negotiation of conflicting ideologies. In Strauss's locale, autonomous functional authority could operate through colleagial systems, in much the same fashion as Goss's advisory bureaucracy. In contrast, the situation in general hospitals - as a total system and not just an isolated part, as was the case with the clinical setting for Goss's work - seems more similar to the farm supply company discussed by Fiedler, where constituent task groups are more characteristic.[27] That is to say, formal routinization of contact and influence between administrative and functional spheres of authority through committee structures, and the use of the medical staff organization by the administrator, provide mechanisms by which policy can be adjusted to each of the separate spheres in the hospital. While providing no guarantee to remove conflict, such formalized mechanisms can help to contain conflict between administrative and functional channels in committee structures, so that the conflict does not spill over into the rest of the structure.

Furthermore, this mechanism appears to work best not only when committees meet regularly, but also when some visible consequences of the meetings are apparent - such as minutes. While not considered "binding," these accretions of the committee appear to focus concern on specific issues rather than allowing them to float freely. Indeed the Municipal administrator, in reviewing the past conflict between the administration and the medical staff suggested that, with regard to the J.C.C.:

> "Its weakness previously was that consensus was not reached and no recommendations were sent to each group. Now, resolutions are passed and sent back to each group. It's a roundtable discussion but without formalizing informal agreements."

It should be pointed out here, that primary concern at these levels is directed at the development of policy. It is, as the Midland administrator stated: "...a place where both the administration and the medical staff can air their views on a variety of issues. Ideas are planted here that become policy later for the hospital and the medical staff." While changes in policy or attempts to change policy may arise out of the inappropriateness of procedures or rules, the latter is more specific and generally not what is at issue. Procedures and rules may be used in conflict over ideological issues, but only insofar as they represent differences in ideological positions - such as who should run the hospital.

Since policy is implemented through the formal, administrative structure as discussed below, the establishment of formal arenas in which ideological differences can be accomodated would appear to be a mechanism to remove disruptions from the dual authority system which are due to differences in ideological viewpoints. Since the influence of functional authority is pervasive throughout the organizational structure, the containment of ideological conflicts between the two spheres in committees at the top of the structure, would appear to be necessary if conflicts in the technology of patient care were not to be unduly disruptive, and a closed system logic applied to the socio-technical levels of the organization. The administrator's formalized contact with the medical staff organization is another mechanism by which administrative and functional matters can be accomodated.

In Strauss' study, ideological conflicts between systems of practice were generally contained by compartmentalizing and homogenizing departments with respect to treatment techniques. Thus, as Strauss pointed out, either a particular method was practiced throughout the organization as was the case in PPI, or separate departments were established, each practicing a different therapeutic method, as in the case of the state mental hospital. Administration was restricted to limited spheres of influence. Such techniques of compartmentalizing administrative and functional concerns is not possible in the general hospital because both spheres of influence flow through the institution. Hence, other mechanisms can be expected to be developed to accomplish the same ends. It is neither a pseudo-bureaucracy nor a pseudo-negotiated order that arises in the general hospital to accomplish this, but rather a combination of the two types of structures in order that both may function.

Control and Coordinative Areas

While James and Pierce discuss these two variables separately, both affect the other in such a way as to make it difficult to keep them empirically separate. Furthermore, several aspects stand out that could be discussed separately, but which are in fact, aspects of control and coordination. Thus, this last section is divided into a series of sub-sections under the generic title of control and coordination.

General control and coordination. This refers to general feelings about the hospital and its environment. In some respects this aspect touches on the inside-outside concept of administration.

In all instances, administrators expressed a sense of frustration with their external environment, while at the same time recognizing a need to deal with it. The sense of frustration centered on the inability to control the changes in their external environment. The feelings were even more acute when administrators compared the degree of control they felt they had within the organization as compared with the outside. This comparison made salient the negative effects that lack of control over external variables had on the internal control the administrator and his assistants felt they had achieved.

The administrative assistant of Urban, for example, directed most of his interview towards government financial intervention in the health system. This intervention was felt to be "...too inconsistent with respect to program development, equipment allocation, and wage and salary negotiations to allow the hospital to plan rationally." Committments were made by the organization that "...were not supported by changing government policy and lack of financing." Even wage negotiations with employees was a contentious issue, affecting the management of people.

Similarly, both the administrators of Urban and Municipal referred to changes in and/or lack of government policy in outpatient areas which prevented the hospital from taking adequate steps to improve its own situation. Furthermore, some conflicts with the medical staff could be traced to attempts by the government to change the health care delivery system. The Municipal administrator stated that: "Many medical staff problems are created outside. For example, the issues of salaries and closing bed space."

To the Urban administrator, changes in nursing education policy, and the government's assumption of the right to determine what services could be offered in an area, represented further sources of external ambiguity which in turn affected the internal operation of the hospital. In this latter case, external ambiguity and changing policy created the likelihood that internal operations would be disrupted. The administrator in this case, as in the others, attempted to buffer or smooth out the changes. In this way the internal operation of the organization could either continue as it had, or changes could be made with the expectation that new patterns would be relatively permanent. Thompson points out the difference between the two techniques for coping with environmental uncertainty when he says that: "...buffering absorbs environmental fluctuations, smoothing or leveling involves attempts to reduce fluctuations in the environment."[28]

Without these techniques, administrators realized that segments of the organization which could be routinized would have been directly subjected to external changes in governmental policy, or even the lack of policy. In many ways then, the administrator and his immediate assistants served as a differentiated unit that would deal with environmental uncertainty in much the same way that Thompson has argued. The lack of control, however, stimulated feelings of frustration, as did the lack of control over sources of role conflict and ambiguity in persons occupying boundary-spanning roles in the organizations studied by Kahn.[29]

The finance director of Southern Religious expressed the feeling of a lack of ability to control external changes in stating: "The government is going to push them (bulk buying, laboratory regional services) in the future. I think the next thing they'll be after is x-ray."

The Southern Municipal administrator expressed somewhat the same opinions.

> "It's hard making long range objectives. For example, our internal operations with CSR and emergency is affected by what the government plans to do, but we don't know yet. The government is pushing dollar cost problems and that means a loss of autonomy. The hospital's objectives become secondary to those of the government. We're scheduled for a regional study....They're just hatchet men for the commission. The government's intervention in labour disputes is a good example."

The Urban administrator expressed similar concerns with respect to the government.

> "Society has delegated funds for programs and services. Regionalization has been a tool to avoid duplication of services. Now, the government has assumed control over what programs and services can be offered in the interest of society. The board used to do this but finds it hard to carry out this function properly now."

Internal control through organizational structure.

Perrow distinguishes between technology and social structure while recognizing the difficulty in maintaining the distinction.[30] The attempt to maintain the distinction at the managerial level not only becomes more difficult, but questionable as to its validity. Indeed, what is raw material and what is social structure from the point of view of management is equally ambiguous.

Not only can the usual production procedures be included in what is called technology, but social structure and organizational form are both the raw materials on which administrators appear to work and which they use as a means to achieve some end (eg. as technology).

In essence, the earlier discussion on medical staff organization reflects the use of organizational structure as technology by management. That is, the formal structure provided a mechanism by which the administrator could influence the medical staff, or could "maneuvre" better patient care. On the other hand, the assistant administrator of Municipal expressed concern that the structure by which formal duties and responsibilities were assigned was not achieving the desired results in terms of coordination. The concomittant attempts to rework the organizational form reflects the fact that social structure can be seen as a raw material. The proper analogy might in fact be technology viewed as raw material, as in the case of engineering science where techniques of production are the raw materials to be improved or worked upon.

In all hospitals, the organizational chart was used to explain the formal division of labour between the administrator and his assistants, as well as for those in the technical sector. The delegation of authority was formally defined and prescribed. Furthermore, the chart reflected the process by which policy was established and recommended at the top, and which was then successively elaborated into rules and regulations the further one went down the organizational chart.

The Urban administrator described the process of policy-procedure translation most succinctly.

> "Control is achieved indirectly through my assistants. If there is a policy for one of their departments, that person is responsible for seeing that procedures are developed and that those procedures are then taken to the procedure committee. If questions arise here about the

> procedures, then I take the policy back to the board with recommendations for changes. Ironing out interdepartmental differences about procedural development is the responsibility of the assistant in charge of those areas. My assistants meet with me and we reach a consensus. Then the assistants call in the departments affected and work out a compromise consistent with the principles worked out in my office."

The elaboration of rules and regulations, indeed their very existence, were both problematic and givens to administrators and assistants alike. They were problematic in that rules and regulations had to be created when policy was established, and also had to be enforced or changed. They were givens, in that personnel were expected to comply with them so that the behavior of organizational participants was "known." This was most evident in interviewing the directors and assistant directors of nursing who referred to and usually displayed their nursing manuals. In all cases, administrators and assistants expected that the agreements which they arrived at in committees or informally among themselves would, in fact, be implemented.

The use of "feedback" such as written reports and statistical indices, was used by all the administrators and assistants to ensure that implementation in fact did occur. Instances where this assumption failed to hold true, indeed, even raising the possibility in the interview. ("What would you do if...."), seemed disturbing to the respondents. In most cases, direct action on the part of the administrator or assistant was suggested. This was a least preferred line of action to these respondents, who preferred instead more accomodative patterns which supported or would support a participative type of management.

For instance, the Midland administrator indicated that he only got involved when interdepartmental problems or personnel problems could not be resolved.

> "I don't get involved usually. I only deal with those problems that can't be handled at the department head level. Interdepartmental problems are best dealt with by the people involved. I may give some guidance. If the problem can't be resolved, then I must make a decision."

His nursing director, in turn, suggested that:

> "I try to get the persons involved together and have them work out the problem. If they can't, then I will make a decision, but I don't like to impose a decision on people. The last resort, of course, is the administrator."

The Municipal administrator indicated that: "I prefer them to resolve the issues at the department level. I don't want to undermine my assistants or the department heads. But if they can't make a decision, then I will."

The line of action of direct involvement was indicative of how serious the failure in assumed implementation of agreements was taken to be. Compliance was to be obtained by involving organizational members in decision-making and rule setting at the lower levels of the organization. It has already been indicated that Urban administrator felt that differences over *translating policy into procedure depended on the establishment of compromises* worked out in his office or in committee structures. And the nursing director of Midland indicated that: "Policy is determined at the head nurse level. You don't need a police force to keep policy obeyed. If they're not followed usually they're out of date and need to be changed." The type of supervision and personnel management styles were emphasized as critical to ensuring that this in fact occurred.

Finally, the existence of committees was also formally prescribed with specific terms of reference.

In short, the structure of the administration was bureaucratically defined in a formal sense, and provided the basic framework around which administrative processes could flow. The implementation of policy and the relaying of information and reports were closely associated with this formal structure.

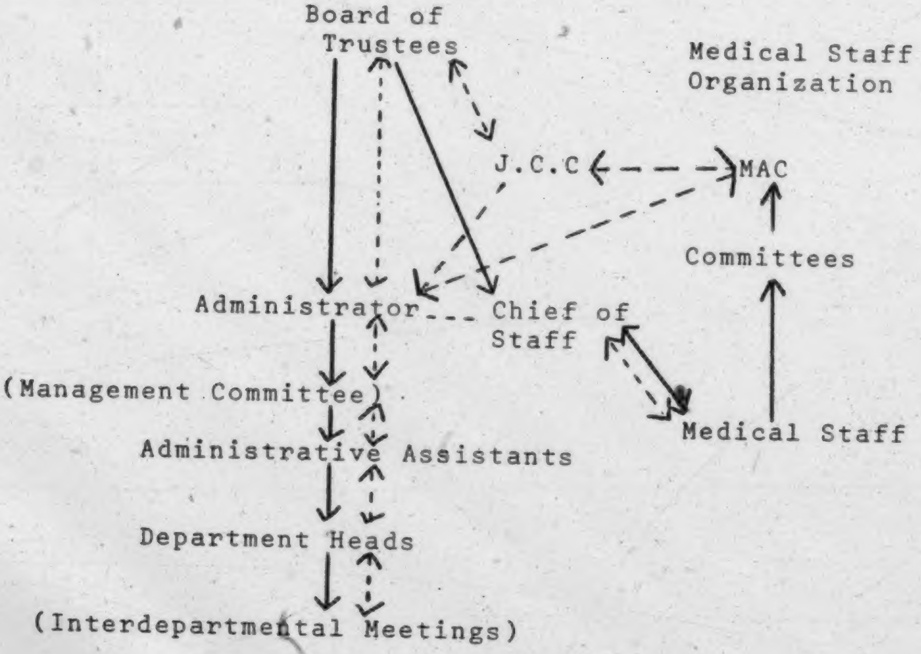
Policy and procedures. The flow chart in Figure 5 illustrates this expected sequence of events as described by most of the respondents.

While policy was determined at the board level, information on which policy was based came up from the administrator. For instance, the Urban administrator stated that:

> "With my administrative officers and the committees, I determine policy recommendations which are sent back to the board for review. This determination of policy is done in conjunction with department heads or directors."

The administrator in turn obtained information and recommendations from his administrative assistants, both individually and from the management committee. Information about policy, and the development of recommendations, were passed on in this committee to assistants by the administrator. These recommendations and information were then passed on to department heads, who were expected to meet formally to help determine procedures and to remove potential conflicts that could arise at the interdepartmental level.

FIGURE FIVE
FLOW CHART OF
ADMINISTRATIVE PROCESS



________________ indicates the flow of policy and authority
---------------- indicates the flow of recommendations, information, and influence.

The nursing director of Southern Religious best summarized this aspect. She stated that: "I meet with the department heads to work out any problems that might arise. We're becoming more aware of this since any changes usually affect some other department." Her colleague in Southern Municipal reiterated a similar concern.

> "Coordination is achieved through department head meetings. Changes in schedules or procedures have to be looked at closely before they're instigated because they are most likely to affect departments other than the one they are intended for."

Department heads were then expected to develop rules and regulations for their departments, once potential interdepartmental problems had been worked out. These were sent back up the channels for approval or changes and then formalized.

Delegation. While the delegation of authority and responsibility was prescribed, in most cases administrator-assistant relationships could be characterized as near peer group. While recognition was given to the fact that the relationship was formally a superior-subordinate one, this formal relationship was more latent than manifest.

As indicated earlier, this was most characteristic of the administrator-nursing director relationship in Midland. Nevertheless, the nursing director of Southern Municipal felt that: "...his door is always open to me and (the assistant administrator). We can walk in and talk to him whenever we need to, and he often drops in to see us." The assistant administrator indicated that: "He is developing the way he should in delegating authority and responsibility, and is presently attempting to carve out a three way arena of action between myself and the business manager."

Assistants were aware of decision-making limits, although in two instances this proved to be of some difficulty in the administrator-assistant relationship. For example, the assistant administrator of Midland indicated that the administrator "...resented his involvement in these (medical staff) areas," while the assistant of Municipal suggested that he and the administrator were still trying to establish decision-making boundaries.

The formal superior-subordinate relationship was also inherent in the use made of reports, and the direction in which reports were sent. In all cases, administrators received reports from the assistants, department heads, and committees that met throughout the organization. This was perhaps best expressed by the administrator of Urban.

> "I have delegated task areas and authority to my administrative officers. This is one mechanism of control over the organization, and I utilize feedback or reports from my officers, plus the various committees, to know what is going on, to ensure that the job is done, and if it was done correctly."

In many respects, this form of feedback made possible and supported the delegation of authority and responsibility. That is to say, administrators had available nonpersonal channels of information to evaluate hospital operation, without having to act directly in the areas delegated to assistants. For example, the Midland administrator used "...variances and reports to keep information about the operation of the hospital." Similarly, the administrator of Southern Religious utilized "...reports to obtain general comparisons and trends within the hospital. It gives me a general idea of how the operation is going." The Southern Municipal administrator also indicated that he used:

> "...reports from the departments to determine about how well they are functioning and if there are any problems arising. This kind of feedback I use as general information. I get this information routinely from committees and my department heads."

Rushing has pointed out that the existence of rules reduces the need for direct supervision.[31] The availability of reports tends to function in much the same way, in that it reduces the administrator's direct supervision. Such indirect forms, in turn, remove friction from interpersonal relationships and permit the development of more colleagial type relationships in a formally superior-subordinate relationship. Indeed, these reports may be a means of ensuring social distance when emphasis on interpersonal relations is high, and close supervision would be disruptive to these channels. Contrary to Rushing's findings, however, administrators in both the medium and large sized hospitals used such reports. While his data refer more to organizational size and the use of rules, the use of records in these organizations may be more a function of the management technology and ideology that are employed. The use of records then becomes necessary to support that technology and the process of delegation. Thus, the administrator can delegate tasks while maintaining an indirect means by which to exert control over the organization.

These formal reports, from both committees and assistants, also stimulated interpersonal contact between the administrator and his assistants. For example, the Midland administrator indicated that: "I use these reports to obtain more information if I think something is wrong or if it raises questions." Questions about reports were often raised in direct face-to-face meetings between the administrator and his assistants. As the director of nursing of Urban put it: "I get to know what he wants in the reports by the kinds of questions he asks me." Also, the director of personnel indicated that:

> "He receives reports from all his assistants and he checks back with us if he wants to know something else that the report has turned him onto. He has a lot of experience in picking out problems that are developing before we're even aware of it. He'll point it out and let us get on with it."

In all the hospitals, administrators and assistants pointed out that frequent and informal contacts were also used to discuss problems that arose in the daily operation of the hospital. The director of nursing of Midland summarized many of these informal meetings as "...discussions about some of the problems we encounter in order to reach a consensus about what to do. I may send out a memorandum in order to clarify what was agreed upon." In this regard the administrator of Midland stated that: "...the written word is a written reference to confirm verbal discussions, to make a record of agreements."

Thus, while the formal structure defines the flow of authority and responsibility in an hierarchical manner, the day-to-day operation operates more on an informal basis. Through the informal structure, consensus about the nature of problems, and possible solutions, are arrived at through a continuous process of definition and the reaching of agreements by establishing compromises. The informal structure, in part, provides the means or structure by which negotiation and consensus (process) can be reached. Formal mechanisms, such as memorandums and committees, may in turn be used to legitimate decisions that have been developed. In all cases, respondents expected that these decisions, arrived at in informal sessions, would be implemented by giving formal directives, and "consulting" with those further down the organizational ladder.

While the formal bureaucracy and the process by which the organizational members developed ways to resolve and cope with problems appeared to be mutually dependent, one other factor helped maintain this reciprocity. This factor relates primarily to the selection of personnel. In essence, it refers to the socialization-selection dichotomy that faces organizations in selecting personnel.

The delegation of authority to assistants depended, in part, on the perceived abilities of those occupying those positions. References were made, in at least three of the hospitals, to "...weeding out the deadwood." Two of the administrators and one of the nursing directors made reference to this in reviewing the historical circumstances surrounding their personal roles. They also expressed the need to select people whom they "...had confidence in and could rely on to carry out their jobs." One of the administrators also referred to the necessity to "...train my people to be independent." Even in the pretest hospital this factor was operative and most clearly expressed. This administrator stated that he had:

> "...a big job in selecting the staff and directors. The objective was to select directors who I had confidence in, and they were then left to set up their departments. With professionals, it's necessary to tell them they have a job to do and to get on with it, and then give them the latitude they need to get the job done. You've got to have confidence in your people."

This quote from the administrator of the pretest hospital illustrates two conditions which would appear to be necessary for delegation and negotiation both to be operative. First, it is recognized that the technology employed by the organization is specialized, which precludes direct administrative control over these areas. The administrator of Urban, for instance, indicated that:

> "You have to recognize the competence of others. After all, I can't do it all myself, even if I wanted to - which I don't. I delegate task areas because these people have specialized training I don't have, although I give them direction and try to keep the ship on the course."

The administrator of Midland felt that: "This hospital isn't rigidly managed. I allow my department heads to make decisions without breathing down their backs." The administrator of Southern Municipal also indicated his role vis-a-vis the competence of his assistants.

> "I attempt to achieve consensus and provide support when it's needed. The administrator doesn't represent all abilities or ideas. You've got to recognize that or you're in trouble. You have to recognize the competency of other people in their own areas. For example, we had four positions about what to do (on the nursing wards). I decided to go with nursing because they know what's going on there."

This makes it necessary to select qualified personnel and creates conditions of mutual dependency. Indeed, in some respects this situation creates conditions approximating those of multiple leadership that were discussed earlier in this chapter.

Secondly, the selection of staff, and "weeding out" of others, increases the likelihood that common expectations and patterns of behavior are shared, which, in turn, support the negotiatory process. This latter point was best illustrated in Midland where the administrator kept a department head who refused to follow "global budgeting," because he still "...did a good job within his department." But this created some conflict between the administrator and the director of nursing, since it created problems for her in having to deal with someone "...who did not share a global orientation."

Thus, for the supportive relationship between bureaucratic arrangements and negotiated orders to function, certain conditions of expertise and shared "perspectives" must also exist. Finally, the selection of personnel who share an ideology and the assumption of expertise, also serves to remove from the interpersonal channels the need for direct supervision, thereby supporting the administrative process of delegation, and the maintaince and support of interpersonal channels. This permits a more accomodative pattern of relationships to develop.

This apparent merging of informal with formal means to develop consensus about problems within the bureaucratic structure, is also illustrated with respect to the resolution of problems on a "stepping-up" basis and the use of committees.

In answering a question on how interdepartmental conflicts were resolved, the pretest administrator pointed out that:

> "There are various administrative levels for resolving conflicts, and while there is an emphasis on personal communication here and solving problems face-to-face, this occurs within definite levels, and these levels exist for the good of good administration."

Across hospitals and respondents, much the same kind of response was elicited to this set of questions on interdepartmental conflict.

It has been pointed out that committee meetings at different levels in the organization were also officially prescribed. Again, the use of bureaucratic structure as a technique to ensure the routine handling of organizational problems can be seen in the way committees were used. In many respects, this represented "programmed coordination."[32] While such committees were used to impart information and direction in a bureaucratic manner, they were also expected to function as arenas in which consensus could be reached about the nature of organizational problems. Furthermore, the solutions to these problems were to be developed and agreed upon in these settings.

James Thompson has argued that such structures will develop in organizations where reciprocal interdependence is high, in order to ensure coordination and control. As has been indicated above, the management committee and departmental head meetings were characteristically, and in particular, described as arenas where this type of interdependence could be dealt with. Indeed, there was strong awareness in all organizations of the high degree of interdependence. Most respondents referred at least once to some attempt to change a department's functioning, only to discover that they had upset the routines of other departments. Even such apparently simple matters as changing the time for rest periods were disruptive to other department. Thus, as noted by the administrator of Urban, the management committee was used to "...work out many of these potential conflicts that would arise in implementing board policy."

The administrator's immediate assistants participated in this committee in order to bring the different concerns of each of the areas together, and to work out acceptable solutions to each of the area participants. As with cases where interdepartmental conflict could not be resolved at the departmental level, however, the administrator held the final authority in mediating nonnegotiable conflicts.

Interdepartmental meetings were also formally prescribed, but dealt with problems of reciprocal interdependency. While information was also imparted and passed on in these meetings, such committees were expected to develop consensus about solutions to organizational problems. In conjunction with the "stepping-up idea" of bureaucracy, however, these consensually defined solutions dealt with more specific issues than did the management committee. Unresolved differences, however, were left to the director of that area, and if they could not be resolved at that level, they were then referred to the administrator. Thus, while such negotiatory structures made it possible for the organizations to function, the bureaucracy in turn supported such structures by routinizing and legitimating their existence, and resolving conflicts that could not be dealt with in such structures.

It would appear that a reciprocal relationship between bureaucracy and the negotiated order best characterizes the general hospital. On the face of it, the hospital appears to function as a bureaucracy, with superior-subordinate relationships, a division of labour, defined delegation of authority and spans of control, and the "step wise" implementation of policy through the production of rules and regulations as one moves down the organizational ladder. On the other hand, the need to achieve coordination and control in a reciprocally interdependent organization, while partly ensured through the functioning of the bureaucracy, is also attained through informal networks where solutions can be agreed upon, and in formal committees which ensure that interdependent parties are given the opportunity to develop consensus about action alternatives. However, the hierarchy of authority intrudes in these settings when agreements cannot be reached. Since Weber's assumption that higher administrators are qualified in all phases of the organization cannot be met in a professional, highly technically developed organization, other means tend to develop by which to enable the bureaucracy to function. These include the informal networks where solutions to organization problems can be negotiated, as well as in the establishment of formal arenas or committees where different levels of ability and specialization can be consistently used to develop consensus on solutions to organizational problems of coordination and control.

It is in this way that formal organizational structure can be used as a technology to achieve the primary goal of the organization - patient care. The formal structure itself is insufficient to ensure the achievement of that goal, as is the informal negotiated structure. The formal structure makes possible the negotiation of agreements and ensures that those agreements are acted upon. The processes of negotiation, on the other hand, make it possible for the formal structure to achieve coordination and control by developing viable solutions to organizational problems in the face of high interdependency of tasks.

Some Implications Concerning the Administrative Processes and the Sociotechnical Environments

A significant point here is that most hospitals including those in this study, are beginning or have begun to implement Management By Objectives (MBO). Management By Objectives may be another managerial bandwagon unless a critical and very close look is taken at the definite and complicated interlinkages among different organizational variables.[33] For MBO to work, certain types of environments must be present. While certain technological forms are most conducive to implementing MBO, especially fluid processing organizations, and others least conducive, the type of authority structure is also important. Rigid, authoritarian hierarchies are least likely candidates for MBO to function. As discussed earlier, however, the perception of the hospital respondents regarding the authority structure, as well as some of the other bureaucratic characteristics, was that authority was not highly structured.

While some skepticism was expressed earlier about these findings, especially with respect to certain objective measures, the pattern of results obtained in Chapter V suggests that the results are, in fact, valid - as long as it is remembered that the data concerns the respondents' perceptions and cognitions of the organizational map. That is to say, given the fact that hospitals employ an intensive technology which is highly specific and developed, although complex, this same technological environment may be particularly well suited, at this stage in the development of hospitals, to fostering the kind of managerial styles recommended by Likert.[34]

Likert, unfortunately, ignored the impact and conditioning effect that the type of technology could have on the management styles he discussed, as well as those he recommended. It is not possible to utilize certain management techniques when the assumptions behind these techniques cannot be met in the industry in question. It is difficult to implement participative management in an industry that processes hard materials, and utilizes a technology that neither requires skilled workers nor permits discretion on the part of the workers.[35] On the other hand, those environments that do not or cannot establish broad objectives are not conducive to MBO either, since subordinates do not know the parameters within which to establish their own objectives. Such situations tend to produce what Thompson calls management by "inspiration," or what Weber identified as charismatic leadership.[36]

Hospitals, by way of contrast, process fluid types of materials, and utilize a technology that, while it is specific, is also complex and permits discretion on the part of some of the workers. While there are boundaries on this discretion, as discussed earlier in Chapter II, they appear to be neither so restrictive nor so specific as to reduce discretion greatly.

Indeed, these boundaries may make discretion more possible, as pointed out in Chapter V.

Given the kind of socio-technical environment which confronts administrators, it may be possible to hypothesize that hospitals are ideal locales for participative management styles, which employ and will increasingly employ committee decision-making and MBO. Furthermore, it would appear that the socio-technical environment has developed in such a way as to make this type of management style possible, if indeed it does exist. There is evidence in the literature regarding the use of committees as decision-making mechanism,[37] and much emphasis on communications and human relations skills. These appear to be necessary precursors to the development of participative management and the utilization of such a management technology as MBO. Finally, that the technology is sufficiently developed in the hospital to ensure effectiveness in outcome, that it requires high levels of training, and provides enough guidelines for workers to complete their tasks, would appear to be sufficient conditions for ensuring continuity of structure, plus control and coordination through the effect of technological constraints on the organizational structure.

In this regard, Kast and Rosenzweig point out that:

> One of the primary means of control in the hospital is through professionalization and the internalization of values and norms of performance which prescribe certain role behaviors for participants. In addition, each of the various groups has mechanisms for self-control. For example, in the medical staff the review procedures for the selection of members of the staff, for tissue examinations, and for medical audits provide some degree of control over the practicing doctor. The board of trustees

> and the administrative staff establish many control procedures, particularly in such areas as accounting, record keeping, and maintenance. These controls are similar to those utilized in many business organizations. The nursing staff is guided by many normative standards, developed through the process of nursing education. These standards regarding role performance serve as a primary means of internalized control.
>
> In addition, various segments establish "hospital procedures," which range all the way from the surgical procedures established by the medical staff to business methods established by the administrator. These hospital procedures provide the basis for the control over relatively programmed activities. However, it should be emphasized that many of the functions in the hospital are nonroutine, and it is difficult to establish structured controls for such activities. In certain areas the hospital utilizes bureaucratic control mechanisms. In many other areas, however, it must rely primarily upon voluntary coordination by the participants themselves.[38]

The data presented in Chapter V suggested that professionalism is highly dependent on situational contraints for the effect it will have on different organizational variables. Kast's argument regarding control through professionalism may still be valid, providing administrators are aware of the situational constraints that will facilitate and hinder the use of professionalism in this way. Indeed, Friedson recognizes that professionalism _per se_, without the necessary structure for control, is insufficient despite the claims of various professional groups to the contrary. The data presented in this chapter suggest that professionalism is dependent on other situational factors for its effect on the organization and may, in fact, be an intervening variable.

Furthermore, the organization is not dependent on voluntary control and coordination to the extent that Kast implies. Rather, the high emphasis on communication and human relations skills, plus the relatively high organizational climate as indicated in such areas as high job satisfaction and high intra-departmental relations, suggest control through normative power, rather than through utilitarian means (note the low job satisfaction with blocked mobility patterns and wages). This kind of control, that is through normative power, is, as many have pointed out, a very strong and immediate means of control and not voluntary or individualistic.

Given the fact that outcomes in hospitals can be reasonably assured, and also that through-put processes are reasonably defined and persistent, thereby ensuring continuity of structure in contrast to Strauss's argument that such structures must be constantly reconstituted, it is possible that concern for interpersonal styles which are essentially interpretive and emergent, rather than purely normative in character, can be allowed to develop. Such emergent structures, however, must at some point be implemented and supported in order for them to be operative. The use of rules and regulations would appear to be one way to ensure that this happens. The socio-technical environment of the hospital appears to support this necessary condition, and thereby permits the emphasis placed on human relations skills and communication, which in turn increases the likelihood that emergent properties will be instituted.

What this suggests, of course, is that bureaucracies and negotiated orders can support one another under conditions of complex technologies. In Strauss's study, where the technology was not nearly so clearly defined as it is in acute care hospitals, nor as complex or even as agreed upon as in the case of acute care institutions, the negotiation of orders functioned as the major means to achieve continuity and change. Structure was always emergent because its bases - treatment ideologies - were always open to debate and emergent. Patient crises were symptomatic of the conflict among the staff and which permeated the interpersonal networks.

This kind of conflict over treatment technology, while evident in acute care hospitals or other similar organizations, is not as prevalent because the basis for order - the technology for treatment - is not open to debate. (At least not treatment arenas as was the case in Strauss's study). As has been indicated by Joan Woodward, the form of the technology employed exerts a profound influence on the social structure of the organization.[39] A defined and stable technology should exert consistent pressures on the social structure, with the consequence that structure does not have to be continuously reconstituted. Only when that technology is being changed, as was the case in one hospital in the study, or when the technology itself is undefined and not agreed upon, will the need arise to continuously reconstitute the social order.

III. SUMMARY: ADMINISTRATIVE PROCESSES AND THE SOCIO-TECHNICAL CONTEXT

The data in Chapter V indicated that the socio-technical environments of the study hospitals could be characterized as participative-consultative on the Likert scale, and that they utilized normative power. Furthermore, it was suggested that this situation was partly a consequence of the technology employed by the organization. While this tended to produce organizations high in bureaucratic rules and demands for technical competence, at the same time, bureaucratic authority, division of labor, and impersonality tended to be low - at least as perceived by the respondents. Furthermore, it was suggested that the technology employed supported the high organizational climates and relatively high negotiatory behavior that were shown to exist. Finally, it was pointed out that the technological basis and the existence of rules ensured continuity of structure, while permitting, and in turn being supported by, the existence of behavior which was accomodative in nature.

The data in this chapter indicated that the administrator was expected to make decisions in traditional areas, but was expected to take a more accomodative stance and "facilitating role" - recommendation giving - in nontraditional areas. While the administrator gave leadership and direction to the board of trustees - a function of both his position in the organization and his assessed stature - he utilized the advisory bureaucracy of the medical staff as a routinized means by which he could influence the medical staff. Involvement in and knowledge about the staff organization, plus conditional exchanges of support, affected the staff's assessed stature of the administrator. This in turn affected his success in his facilitating role in the condition of multiple leadership which was shown to exist. The administrator's participation in the advisory bureaucracy, as well as the use of the Joint Conference Committee, were seen as mechanisms by which administrative and functional concerns and conflicts could be handled in a "routinized" manner. While the structure to deal with functional and administrative issues was essentially bureaucratic, the processes by which issues were dealt with were essentially negotiatory. These bureaucratic-negotiatory structures were seen to be techniques by which conflict could be contained to some extent at the managerial level of the organization, instead of spilling over into the socio-technical levels. Such structures were necessary because the two authority structures permeated the socio-technical environment.

Finally, evidence was presented to support the contention in the previous chapter that the managerial styles were essentially participative-consultative. Furthermore, it was indicated that the structure of the organization - essentially bureaucratic in nature - provided the framework around which the administrative process could flow. This process was essentially negotiatory in character, dependent on the bureaucratic elements of delegation of authority to assistants, and the use of informal channels, as well as the routinization of committees, to develop consensus about solutions to problems in an interdependent task structure. The use of formal reports were seen as supportive of the delegation process, as was the selection of qualified personnel and the sharing of perspectives. The "step wise" manner in which conflict resolution and rule setting were seen to occur were important elements supporting the administrative processes, and which merged the bureaucratic with the negotiatory elements of the process. The emphasis on supervision and the use of interpersonal channels of communication by administrators and assistants, lent support to, and in turn were supported by, the findings on the socio-technical environment which were presented in Chapter V.

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CHAPTER VII

SUMMARY OF FINDINGS AND IMPLICATIONS OF THE STUDY

The purpose of the present study was to analyze the role of the hospital administrator, the organizational environment within which the administrator enacted his role, the processes by which the administrator coped with the nature of his role, and the power and authority systems in the hospital.

Chapter II reviewed the literature pertaining to complex organizations, including general acute care hospitals. The open system-closed system model was used to discuss the nature of bureaucracy and the negotiated order, as well as the impact that technology has on organizational behavior. The nature of the administrator's role, as discussed in the literature, was presented. Propositions relating professionalism to the degree of bureaucracy, negotiation, participation in decision-making, and role conflict and ambiguity were discussed. Two propositions were also presented relating role conflict and role ambiguity to bureaucracy, and bureaucracy to negotiation. Finally, two propositions were discussed regarding role consensus about the administrator's role and the structural characteristics of the role.

Chapter III described the methodology used to achieve the purpose of the study. Survey questionnaires were utilized to obtain information about the organizational environments in the socio-technical sectors of the organizations, as well as about the role conceptions of the administrator's role. Interviews were conducted in the four participating hospitals to obtain information concerning the immediate work environment of the administrator, as well as to determine the nature and types of administrative processes that were used.

Chapter IV presented the data for the hypotheses. Additional data analysis was presented regarding the effect of selected controls on the relationship between bureaucracy and negotiation.

Professionalism was found to be negatively related to the hierarchy of authority and to the division of labour, but not related to bureaucratic rules, procedures, impersonality or technical competency. Nor was professionalism related to negotiation, or to role conflict and role ambiguity. Professionalism was positively related to committee decision-making, but not to interpersonal decision-making. Hypothesis Eight predicted a negative relationship between bureaucracy and negotiation. Only committee negotiation was negatively related to the bureaucratic division of labour. Task negotiation was positively associated with bureaucratic authority, procedural specifications and impersonality, agreements negotiation with bureaucratic rules, and committee negotiation with bureaucratic demands for technical competency. The interdependent nature of task structures and the intensive technology characteristic of acute care institutions, were suggested as possible explanations of the above findings.

Chapter V summarized the data on organizational climates and structures for all the hospitals. In general, positive climates were shown to exist, and the data suggested that these organizations were both normative and participative.

An intercorrelational analysis of the organizational variables indicated that organizational position, department, and professionalism were not related to any of the organizational variables. Supervisory skills, however, were related to most of the organizational variables and appeared to play a major linking-pin effect in the complex relationships among the organizational variables. Each of the three supervisory skills also tended to have strong and selected effects on different organizational factors. Human relations skills tended to strongly affect attitudinal factors such as job satisfaction, while administrative skills appeared to have a more pronounced influence on structural variables, such a role conflict and coordination. Technical skills had a moderate effect on all the variables.

Participation in formal and informal decision-making were positively related to each other, and also to intradepartmental relations.

These findings, and the positive organizational climates, were explained in terms of the intensive technology utilized by the organizations. In conjunction with the data regarding the degree of bureaucracy and negotiation, it was suggested that the bureaucratic structure and the negotiated order were functionally related due to the nature of the technology employed and the positive organizational climates. These organizational climates, while supporting this functional relationship, were, in turn, supported by this relationship.

An analysis of the specific organizational climates and administrative roles, processes and structures, revealed both similarities and differences among the four hospitals. Common to all administrators were the delegation of task areas to administrative officers, the use of feedback to maintain control, the use of committee structures to maintain coordination, and the role of the administrator as integrator and information processor.

The Midland and Southern Religious Hospitals were similar in socio-technical environments and were the most positive of all the hospitals. While both administrators were oriented towards the medical staff, the Midland administrator most clearly organized his role around the medical staff organization. Compared to the other administrators, however, the administrator of Urban had the most extensive and clearly developed delegated task structure, as well as a greater external orientation.

The Southern Municipal Hospital was introducing technological innovations in its nursing care sectors, with concommitant conflict between the medical staff and the administration. The close administrator/board relationship, the lack of a viable staff organization, the nonroutinized meetings of the J.C.C., and the dual privileges system for the medical staff in the town's two hospitals, were factors which appeared to contribute to the system wide conflict in this hospital.

Chapter VI reviewed the questionnaire and interview data on the administrator. The various role senders - board of trustees, medical staff, administrative assistants and administrators - were in greater agreement about the amount of power each group should have in traditional than in nontraditional areas.

In addition, the administrator was generally expected to have decision-making power in traditional areas, whereas in nontraditional areas he was expected to have recommendation giving power. In nontraditional areas, the range of tolerable behavior was small. This situation, and the conditions of multiple leadership that were shown to exist, suggested that the administrator played a facilitating role in the management triangle, and that this role was potentially conflictful in nontraditional areas. It was also in these areas where board and medical staff tended to have greater disagreements about the degree of power the administrator should have in decision-making.

Nevertheless, the medical staff did express a fairly high level of acceptance of the administrator in nontraditional areas relative to the recommendation giving power in his facilitating role in these areas. The interview data suggested that most of the administrators attempted to enact their roles within these constraints, and used the medical staff hierarchy as a means to influence policy and decisions regarding medical care and medical staff functioning. The data also suggested that the administrator utilized these formal, bureaucratically defined structures, including formally prescribed committees, to contain conflict over policy, and to negotiate and influence the kind of policy that was agreed upon. The functional reciprocity between bureaucracy and the negotiated order that was shown to exist in the socio-technical sectors of the organization, was also shown to exist at the managerial level of the organization.

This functional relationship was also shown to exist between the managerial level and the socio-technical level of the organization. That is, the use of formally prescribed committee meetings, the formal flow of reports and information, and the step-wise implementation of policy into rules and regulations, both supported and in turn were supported by, the negotiation of agreements among members of the hierarchy. The emphasis on human relations skills, communication, and negotiation at the management levels was paralleled in the socio-technical sectors of the organization, as discussed in the previous chapter.

Thus, the administrative process and the administrator's ability to cope with the peculiar power and authority structure of the hospital, both with respect to the management triangle and the socio-technical sector, tended to involve a functional relationship between the bureaucracy and the negotiated order.

Implications and Suggestions for Research

Organizations, whether they process animate or inanimate materials, employ different forms of technology which are more or less effective. The type of technology and its effectiveness in altering the raw material are known to affect organizational structure, and are also likely to affect the structure of management.

This study has suggested that the complex and intensive technology of the acute care institution, while increasing the structural complexity of these organizations, also functions to break down objective task differences among occupational groups. In the oil industry a process production model exists, and the technology and task structures confronting production workers are similar to that in the acute care organization. Despite the demand for specialized and highly trained employees, the task structures also tend to break down objective task differences among workers, forcing them to work in teams and as colleagues.

Indeed, as technological forms advance, there is some evidence to suggest that in advanced industries there is a return to craftsman-like jobs and work structures.[1] This suggests a cyclical development in industrial forms. That is, from the idealized man as total craftsman, to the heavy handed, atomistic, and routine tasks of the mass production era, to the advanced, automated industry where man as total craftsman emerges again but only in conjunctive colleagueship with other workers. While this latter phase is similar to earlier craftsman-like periods, it differs in the rationalization and complexity of knowledge, is based on process rather than unit production, is more technically specific and less intutitive or artistic, and finally, tasks are performed in conjunction with others and not in isolation.

It is possible that Durkheim's mechanistic/organic/ pseudo mechanistic developmental model of society has a more explicit relationship to the characteristics of the technological forms employed during different historical periods.[2] If this is true, then it is possible that the bases for new social forms are emerging in industries which employ intensive or advanced process production technologies.[3] Historical sociologists might do well to analyse present technological forms and compare them with previous forms. In addition, a reconsideration of the contributions that both Sorokin[4] and Durkheim have to offer each other would be in order.

Historical sociology would also find a worthy area of research in tracing the development of medical technology and its impact on the structure of the hospital organization. Rosen's[5] and Perrow's[6] work are only beginnings in this regard. More specific analyses of organizational forms and technological forms - indeed a more adequate system of categorizing technological forms - are needed. As has already been suggested, the participative styles of management employed in the hospitals that were studied, and the adoption of such management tools as MBO, PERT, and PPS, may not be accidental, but due to the impact of the type of technology that is developing in these organizations. Indeed, the analysis by Kouvner of the technology employed in nursing care units and the conclusions which he drew regarding the reorganization of nursing units, provide some support for the above.[7]

Irrespective of the implications for "grand theory," there is a definite need for better and more detailed analyses and measurements of technology than presently exist. Such an analysis should make possible the comparison of technologies employed in transforming inanimate materials (both hard and soft), animate, and symbolic forms of raw material.

One of the consequences of such an analysis would be to improve the chances for developing a management technology, as well as to further an understanding of the relationship between management and organizational forms. Joan Woodward has suggested that there is no one set of management principles and structures.[8] Rather, she suggests that the form of management should be tailored to the type of technology the organization employs. The analysis presented in this study suggests that a participative-consultative management structure seems to be emergent in the modern hospital. In this structure, task areas are delegated, and control is obtained through feedback and routinized committees where differences among personnel from different organizational sectors are routinely negotiated. This structure appears to be based on an intensive technology which the acute care institution employs in the pursuit of treating acute illnesses. Hospital administrators continue to complain that they have no model from which to learn. A continuing introspective analysis, focused on the relationship between technology, social structure, and management forms (including management as technology) may provide the model they seek.

Indeed, this study suggests that the administrator, in organizations which employ a developed but complex technology, should seek to ensure the regularization of arenas for negotiation. It also implies that the hospital administrator will be more likely to delegate task areas in the future while becoming more externally oriented. This suggests that more research is in order on the processes by which the delegation of task areas occurs, and on the mechanisms for achieving control.

Furthermore, if the trends and concerns identified in this study are generalizable, administrators in the future should expect to play an even greater generalist-integrator role, of which no small part will be the mediation and identification of conflicts among all organizational sectors, including the medical staff structure. In addition, mediating the relationship between the institution and its environment, of which governmental action appears to be a major part, will increasingly become part of the administrator's role. Since administrators in this study often provided the information and policy recommendations in this area to the board, a more careful look at the legal responsibility of the board vis-a-vis the administrator is warranted. Indeed, the role of the board in the future should be clarified by both the institution and the government.

Furthermore, in view of the very considerable degree of ambiguity that government policy, or lack thereof, presents to acute care institutions, there is an apparent need to establish firm guidelines about what is to be achieved through the health care system. The continuous changes in governmental policy, and the lack of policy, reduce the acute care institution's ability to organize services, and promote a tendency on the part of the institution to ignore governmental directives due to the expectation that these directives will be changed anyway. While restraining institutions in some areas, this situation also promotes the belief among acute care institutions that they should act and plan irrespective of the general directions specified by government and society.

The study also suggests that the medical staff structure and its functioning is now, should be, and will be, of critical concern to the administrator in the future. In addition, the development of more accommodative mechanisms between the administrative and operative segments of the organization will be necessary. The administrator will play a large role in constructing these regularized, accommodative mechanisms, but his attempts to do so should proceed on the recognition that his facilitating role in this regard does not permit him the luxury of administrative decree. This is not only unnecessary, but would also be dysfunctional, since the recommendation giving powers of the administrator are more powerful than they appear to be on the surface. This statement, of course, is contingent on the fact that such power rests on the administrator's assessed stature by the medical staff.

Ensuring that the medical staff organization is properly set up and functioning, and using that structure as a bureaucratized means by which to ensure contact with and influence within the medical staff, will be major mechanisms in the development of the medical staff's assessed stature of the administrator and his consequent ability to develop other accommodative modes. Indeed, the study has suggested that an important part of the hospital administrator's management technology is the recognition and facilitation of the functional relationship between bureaucracy and negotiation in achieving the goals of the organization.

What this study implies with regard to hospital administrators and the administrative process is not directly applicable to other health settings. In organizations oriented towards the treatment, maintenance, or rehabilitation of persons suffering from chronic illnesses, and where the technology is neither as specific and/or effective as in the acute care institution, the management technology employed may also have to differ. Indeed, the administrator in organizations where milieu therapy and group therapy are practiced, may have to work towards removing bureaucratic structures, while facilitating the development of a negotiated order. In his attempts to flatten the organizational structure, the administrator should also be aware that the lack of an effective technology, and long undefined career passages for patients in such organizations, tend to create "pseudo-crises".[9] Perhaps it is not the removal of all aspects of bureaucracy that is needed, but rather an accommodation between the negotiated order and bureaucracy such as appears to exist in acute care institutions. The overreaction of milieu therapists to bureaucracy, and, to their minds, its representatives such as administrators, suggests again the need for administrators to manage their assessed statures and to utilize the facilitating role they could play in such organizations.

Finally, the status of the community health centre in

Canada, while ambiguous and uncertain at this point in time, suggests the need to recognize the dual impact on the centre of acute care technology and preventive technology (if such exists). Indeed, the role of the hospital administrator may provide some guidelines to the role of the administrator in the community health centre. Since the proposals for such centres are for integrated and independent units, there is the expectation that a wide range of personnel will be included. Furthermore, there is a clear expectation that these organizational participants will act as teams in both the treatment and prevention of illness. This means that personnel with both specific and diffuse orientations[10] will be thrown together, and the likelihood is low that cooperation between team members will develop.

It will be necessary for administrators in such settings not only to manage their own assessed statures, but to have enough awareness of organizational form and the influence of situational constraints on organizational behavior, to be able to manage the assessed stature of others. Those who share specific orientations are most likely to cooperate with one another, employ specific and usually effective technologies.[11] Conversely, those with more diffuse orientations will find it hard to obtain the cooperation of others with more specific orientations and therapies. Indeed, their stature in the health centre is likely to be low. Administrators who have a clear conception of the functional relationship between bureaucracy and negotiation that has been identified in this study, and who are able to regularize arenas where the negotiation of orientational differences can be mediated, may be the keys to making such centres operational.

FOOTNOTES

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APPENDIX A

TABLES

TABLE 1

HOSPITAL BY

INTRA-DEPARTMENTAL COMMITTEE DECISION-MAKING

	INTRA-DEPARTMENTAL COMMITTEE DECISION-MAKING									
	Low		Medium		High		No Answer		Total	
Hospital	N	%	N	%	N	%	N	%	N	%
Urban	235	33.2	276	39.0	179	25.3	18	2.5	708	100.0
Midland	41	34.7	44	37.3	27	22.9	6	5.1	118	100.0
Southern Municipal	41	26.3	69	44.2	41	26.3	5	3.2	156	100.0
Southern Religious	38	34.9	37	33.9	31	28.4	3	2.8	109	100.0
Total	355	32.5	426	39.0	278	25.4	32	2.9	1091	100.0

TABLE 2

HOSPITAL BY

INTER-PERSONAL DECISION-MAKING

	INTER-PERSONAL DECISION-MAKING									
	Low		Medium		High		No Answer		Total	
Hospital	N	%	N	%	N	%	N	%	N	%
Urban	169	23.9	301	42.5	216	30.5	22	3.1	708	100.0
Midland	18	15.3	55	46.6	39	33.1	6	5.1	118	100.0
Southern Municipal	30	19.2	71	45.5	49	31.4	6	3.8	156	100.0
Southern Religious	24	22.0	32	29.4	51	46.8	2	1.8	109	100.0
Total	241	22.0	459	42.0	355	32.5	36	3.2	1091	100.0

TABLE 3

HOSPITAL BY

SUPERVISORS' TECHNICAL SKILLS

Hospital	Low		Medium		High		No Answer		Total	
	N	%	N	%	N	%	N	%	N	%
Urban	25	3.5	151	21.3	521	73.6	11	1.6	708	100.0
Midland	7	5.9	19	16.1	90	76.3	2	1.7	118	100.0
Southern Municipal	5	3.2	32	20.5	119	76.3	0	0.0	156	100.0
Southern Religious	5	4.6	18	16.5	84	77.1	2	1.8	109	100.0
Total	42	3.8	220	20.1	814	74.6	15	1.3	1091	100.0

TABLE 4

HOSPITAL BY

RESPONDENTS' PERCEPTION OF SUPERVISORS' "JOB KNOW HOW"

Hospital	Low		Medium		High		No Answer		Total	
	N	%	N	%	N	%	N	%	N	%
Urban	68	9.6	185	26.1	442	62.4	13	1.8	708	100.0
Midland	14	11.9	25	21.2	75	63.6	4	3.4	118	100.0
Southern Municipal	13	8.3	38	24.4	103	66.0	2	1.3	156	100.0
Southern Religious	7	6.4	27	24.8	72	66.1	3	2.8	109	100.0
Total	102	9.3	275	25.2	692	63.4	22	2.0	1091	100.0

TABLE 5

HOSPITAL BY

RESPONDENTS' PERCEPTION OF SUPERVISORS' JOB KNOWLEDGE

Hospital	Low		Medium		High		No Answer		Total	
	N	%	N	%	N	%	N	%	N	%
Urban	55	7.8	166	23.4	475	67.1	12	1.7	708	100.0
Midland	11	9.3	15	12.7	89	75.4	3	2.5	118	100.0
Southern Municipal	11	7.1	47	30.1	98	62.8	0	0.0	156	100.0
Southern Religious	8	7.3	24	22.0	75	68.8	2	1.8	109	100.0
Total	85	7.7	252	23.0	737	67.5	17	1.5	1196	100.0

TABLE 6

HOSPITAL BY

RESPONDENTS' PERCEPTION OF SUPERVISORS' EQUIPMENT KNOWLEDGE

Hospital	Low		Medium		High		No Answer		Total	
	N	%	N	%	N	%	N	%	N	%
Urban	40	5.7	137	19.3	515	72.7	16	2.3	708	100.0
Midland	10	8.4	17	14.4	90	76.3	1	0.8	118	100.0
Southern Municipal	8	5.1	41	26.3	106	68.0	1	0.6	156	100.0
Southern Religious	7	6.4	27	24.8	73	67.0	2	1.8	109	100.0
Total	65	5.9	222	20.3	784	71.8	20	1.8	1091	100.0

TABLE 7

HOSPITAL BY

SUPERVISORS' HUMAN RELATIONS SKILLS

Hospital	Low		Medium		High		No Answer		Total	
	N	%	N	%	N	%	N	%	N	%
Urban	29	4.1	167	23.6	509	71.6	3	0.4	708	100.0
Midland	2	1.7	19	16.1	97	82.2	0	0.0	118	100.0
Southern Municipal	7	4.5	33	21.2	115	73.7	1	0.6	156	100.0
Southern Religious	0	0.0	18	16.5	89	81.7	2	1.8	109	100.0
Total	38	3.4	237	21.7	810	74.2	6	0.5	1091	100.0

TABLE 8

HOSPITAL BY

RESPONDENTS' PERCEPTION OF SUPERVISORS' SUPPORT

Hospital	Low		Medium		High		No Answer		Total	
	N	%	N	%	N	%	N	%	N	%
Urban	71	10.0	170	24.0	460	65.0	7	1.0	708	100.0
Midland	7	5.9	21	17.8	90	76.3	0	0.0	118	100.0
Southern Municipal	15	9.6	31	19.9	109	69.9	1	0.6	156	100.0
Southern Religious	7	6.4	14	12.8	86	78.9	2	1.8	109	100.0
Total	100	9.1	236	21.6	745	68.2	10	0.9	1091	100.0

TABLE 9

HOSPITAL BY

RESPONDENTS' ABILITY TO DISCUSS JOBS WITH SUPERVISOR

Hospital	Low		Medium		High		No Answer		Total	
	N	%	N	%	N	%	N	%	N	%
Urban	95	13.4	169	23.9	443	62.6	1	0.1	708	100.0
Midland	6	5.1	21	17.8	91	77.1	0	0.0	105	100.0
Southern Municipal	14	9.0	30	19.2	112	71.8	0	0.0	156	100.0
Southern Religious	3	2.8	23	21.1	81	74.3	2	1.8	109	100.0
Total	118	10.8	243	22.2	727	66.6	3	0.2	1091	100.0

TABLE 10

HOSPITAL BY

SUPERVISORS' WORK APPRECIATION

Hospital	Low		Medium		High		No Answer		Total	
	N	%	N	%	N	%	N	%	N	%
Urban	41	5.8	228	32.2	431	60.9	8	1.1	708	100.0
Midland	5	4.2	30	25.4	82	69.5	1	0.8	118	100.0
Southern Municipal	13	8.3	36	23.1	105	67.3	2	1.3	156	100.0
Southern Religious	1	0.9	22	20.2	83	76.1	3	2.8	109	100.0
Total	60	5.4	316	28.9	701	64.2	14	1.2	1091	100.0

TABLE 11

HOSPITAL BY

SUPERVISOR SEEKS RESPONDENTS' IDEAS AND OPINIONS

Hospital	Low		Medium		High		No Answer		Total	
	N	%	N	%	N	%	N	%	N	%
Urban	99	14.0	206	29.1	395	55.8	8	1.1	708	100.0
Midland	9	7.6	30	25.4	78	66.1	1	0.8	118	100.0
Southern Municipal	17	10.9	47	30.1	91	58.3	1	0.6	156	100.0
Southern Religious	7	6.4	22	20.2	78	71.6	2	1.8	109	100.0
Total	132	12.0	305	27.9	642	58.8	12	1.0	1091	100.0

TABLE 12

HOSPITAL BY

SUPERVISORS' SUPPORT

Hospital	Low		Medium		High		No Answer		Total	
	N	%	N	%	N	%	N	%	N	%
Urban	87	12.3	162	22.9	451	63.7	8	1.1	708	100.0
Midland	8	6.8	12	10.2	95	80.5	3	2.5	118	100.0
Southern Municipal	21	13.5	28	17.9	106	67.9	1	0.6	156	100.0
Southern Religious	9	8.3	17	15.6	79	72.5	4	3.7	109	100.0
Total	125	11.4	219	20.0	731	67.0	16	1.4	1091	100.0

TABLE 13

HOSPITAL BY

SUPERVISORS' ADMINISTRATIVE SKILLS

Hospital	Low		Medium		High		No Answer		Total	
	N	%	N	%	N	%	N	%	N	%
Urban	11	1.6	313	44.2	379	53.5	5	0.7	708	100.0
Midland	1	0.8	27	22.9	89	75.4	1	0.8	118	100.0
Southern Municipal	7	4.5	63	40.4	85	54.5	1	0.6	156	100.0
Southern Religious	2	1.8	33	30.3	72	66.1	2	1.8	109	100.0
Total	21	1.9	436	39.9	625	57.2	9	0.8	1091	100.0

TABLE 14

HOSPITAL BY

RESPONDENTS' PERCEPTION OF PERFORMING OTHERS WORK

Hospital	Low		Medium		High		No Answer		Total	
	N	%	N	%	N	%	N	%	N	%
Urban	361	51.0	291	41.1	48	6.8	8	1.1	708	100.0
Midland	78	66.1	34	28.8	4	3.4	2	1.7	118	100.0
Southern Municipal	82	52.6	59	37.8	15	9.6	0	0.0	156	100.0
Southern Religious	60	55.0	39	35.8	8	7.3	2	1.8	109	100.0
Total	581	53.2	423	38.7	75	6.8	12	1.0	1091	100.0

TABLE 15

HOSPITAL BY RESPONDENTS' PERCEPTION OF LOST TIME

Hospital	Low		Medium		High		No Answer		Total	
	N	%	N	%	N	%	N	%	N	%
Urban	502	70.9	175	24.7	20	2.8	11	1.6	708	100.0
Midland	98	83.1	15	12.7	1	0.8	4	3.4	118	100.0
Southern Municipal	107	68.6	36	23.1	11	7.1	2	1.3	156	100.0
Southern Religious	90	82.6	13	11.9	3	2.8	3	2.8	109	100.0
Total	797	73.0	239	21.9	35	3.2	20	1.8	1091	100.0

TABLE 16

HOSPITAL BY

RESPONDENTS' PERCEPTION OF WORK ASSIGNMENT CONFLICTS

Hospital	Low		Medium		High		No Answer		Total	
	N	%	N	%	N	%	N	%	N	%
Urban	625	88.3	68	9.6	10	1.4	5	0.7	708	100.0
Midland	111	94.1	6	5.1	0	0.0	1	0.8	118	100.0
Southern Municipal	138	88.5	15	9.6	2	1.3	1	0.6	156	100.0
Southern Religious	98	89.9	7	6.4	2	1.8	2	1.8	109	100.0
Total	972	89.0	96	8.7	14	1.2	9	0.8	1091	100.0

TABLE 17

HOSPITAL BY

TOTAL JOB SATISFACTION

Hospital	Low		Medium		High		No Answer		Total	
	N	%	N	%	N	%	N	%	N	%
Urban	22	2.9	321	45.3	359	50.7	6	1.1	708	100.0
Midland	2	1.7	39	32.9	76	64.4	1	1.0	118	100.0
Southern Municipal	3	1.9	61	39.1	92	59.0	0	0.0	156	100.0
Southern Religious	3	2.8	28	25.7	78	71.6	0	0.0	109	100.0
Total	30	2.7	449	41.4	605	55.8	7	0.3	1091	100.0

TABLE 18

HOSPITAL BY

RESPONDENT SATISFACTION WITH SUPERVISION

Hospital	Low		Medium		High		No Answer		Total	
	N	%	N	%	N	%	N	%	N	%
Urban	64	9.0	165	23.3	471	66.5	8	1.1	708	100.0
Midland	4	3.4	23	19.5	89	75.4	2	1.7	118	100.0
Southern Municipal	12	7.7	36	23.1	106	67.9	2	1.3	156	100.0
Southern Religious	6	5.5	21	19.3	79	72.5	3	2.8	109	100.0
Total	86	7.8	245	22.4	745	68.2	15	1.3	1091	100.0

TABLE 19

HOSPITAL BY

SATISFACTION WITH PROMOTION

Hospital	Low		Medium		High		No Answer		Total	
	N	%	N	%	N	%	N	%	N	%
Urban	257	36.3	197	27.8	214	30.2	40	5.7	708	100.0
Midland	38	32.2	31	26.3	43	36.4	6	5.1	118	100.0
Southern Municipal	44	28.2	39	25.0	62	39.7	11	7.1	156	100.0
Southern Religious	35	32.1	26	23.9	43	39.5	5	4.6	109	100.0
Total	374	34.2	293	26.8	362	33.1	62	5.6	1091	100.0

TABLE 20

HOSPITAL BY

SATISFACTION WITH SALARY

Hospital	Low		Medium		High		No Answer		Total	
	N	%	N	%	N	%	N	%	N	%
Urban	209	29.5	260	36.7	232	32.8	7	1.0	708	100.0
Midland	21	17.8	42	35.6	53	44.9	2	1.7	118	100.0
Southern Municipal	10	6.4	48	30.8	98	62.8	0	0.0	156	100.0
Southern Religious	8	7.3	25	22.9	76	69.7	0	0.0	109	100.0
Total	248	22.7	375	34.3	459	42.0	9	0.8	1091	100.0

TABLE 21

HOSPITAL BY

JOB SATISFACTION WITH WORKING CONDITIONS

	JOB SATISFACTION WITH WORKING CONDITIONS									
	Low		Medium		High		No Answer		Total	
Hospital	N	%	N	%	N	%	N	%	N	%
Urban	46	6.5	242	34.2	408	57.6	12	1.7	708	100.0
Midland	5	4.2	28	23.7	84	71.2	1	0.8	118	100.0
Southern Municipal	16	10.3	53	34.0	86	55.1	1	0.6	156	100.0
Southern Religious	3	2.8	30	27.5	75	68.8	1	0.9	109	100.0
Total	70	6.4	353	32.3	653	59.8	15	1.3	1091	100.0

TABLE 22

HOSPITAL BY

JOB SATISFACTION WITH WORK DECISION OPPORTUNITY

Hospital	Low		Medium		High		No Answer		Total	
	N	%	N	%	N	%	N	%	N	%
Urban	71	10.0	215	30.4	414	58.5	8	1.1	708	100.0
Midland	4	3.4	24	20.3	88	74.6	2	1.7	118	100.0
Southern Municipal	14	9.0	38	24.4	103	66.0	1	0.6	156	100.0
Southern Religious	7	6.4	23	21.1	78	71.6	1	0.9	109	100.0
Total	96	8.7	300	27.4	683	62.6	12	1.0	1091	100.0

TABLE 23

HOSPITAL BY

JOB SATISFACTION WITH WORK RELATIONS

Hospital	Low		Medium		High		No Answer		Total	
	N	%	N	%	N	%	N	%	N	%
Urban	18	2.5	133	18.8	551	77.8	6	0.8	708	100.0
Midland	2	1.7	17	14.4	98	83.1	1	0.8	118	100.0
Southern Municipal	2	1.3	31	19.9	122	78.2	1	0.6	156	100.0
Southern Religious	3	2.8	18	16.5	88	80.7	0	0.0	109	100.0
Total	25	2.2	199	18.2	859	78.7	8	0.7	1091	100.0

TABLE 24

HOSPITAL BY

INTRA-DEPARTMENTAL COORDINATION

Hospital	Low		Medium		High		No Answer		Total	
	N	%	N	%	N	%	N	%	N	%
Urban	8	1.1	229	32.3	466	65.8	5	0.7	708	100.0
Midland	0	0.0	16	13.6	101	85.6	1	0.8	118	100.0
Southern Municipal	3	1.9	47	30.1	105	67.3	1	0.6	156	100.0
Southern Religious	0	0.0	22	20.2	85	78.0	2	1.8	109	100.0
Total	11	1.0	314	28.7	757	69.3	9	0.8	1091	100.0

TABLE 25

HOSPITAL BY

INTRA-DEPARTMENTAL RELATIONS

Hospital	Low		Medium		High		No Answer		Total	
	N	%	N	%	N	%	N	%	N	%
Urban	13	1.8	163	23.0	514	72.6	18	2.5	708	100.0
Midland	1	0.8	20	17.0	97	82.2	0	0.0	118	100.0
Southern Municipal	4	2.6	34	21.8	115	73.7	3	1.9	156	100.0
Southern Religious	0	0.0	16	14.7	91	83.5	2	1.8	109	100.0
Total	18	1.6	233	21.3	817	74.8	23	2.1	1091	100.0

TABLE 26

HOSPITAL BY

TOTAL ROLE CONFLICT

Hospital	Low		Medium		High		No Answer		Total	
	N	%	N	%	N	%	N	%	N	%
Urban	202	28.5	452	63.8	48	6.8	6	0.8	708	100.0
Midland	49	41.5	66	55.9	2	1.7	1	0.8	118	100.0
Southern Municipal	53	34.0	93	59.6	9	5.8	1	0.6	156	100.0
Southern Religious	39	35.8	65	59.6	5	4.6	0	0.0	109	100.0
Total	343	31.4	676	61.9	64	5.8	8	0.7	1091	100.0

TABLE 27

HOSPITAL BY

ROLE CONFLICT DUE TO LACK OF PERSONNEL OR EQUIPMENT

Hospital	Strongly Agree		Agree		Un-decided		Disagree		Strongly Disagree		No Answer		Total	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Urban	24	3.4	109	15.4	69	9.7	373	52.7	127	17.9	6	0.8	708	100.0
Midland	2	1.7	13	11.0	6	5.1	71	60.2	26	22.0	0	0.0	118	100.0
Southern Municipal	3	1.9	33	21.2	21	13.5	74	47.4	24	15.4	1	0.6	156	100.0
Southern Religious	5	4.6	13	11.9	13	11.9	56	51.4	21	19.3	1	0.9	109	100.0
Total	34	3.1	168	15.3	109	9.9	574	52.6	198	18.1	8	0.7	1091	100.0

TABLE 28

HOSPITAL BY

ROLE CONFLICT DUE TO LACK OF ADEQUATE RESOURCES AND MATERIAL

Hospital	Strongly Agree		Agree		Un-decided		Disagree		Strongly Disagree		No Answer		Total	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Urban	94	13.3	297	42.0	82	11.6	177	25.0	50	7.1	7	1.1	707	100.0
Midland Southern	11	9.3	46	39.0	19	16.1	35	29.7	7	5.9	0	0.0	118	100.0
Municipal Southern	11	7.1	72	46.2	17	10.7	48	30.8	8	5.1	0	0.0	156	100.0
Religious	8	7.3	42	38.5	10	9.2	39	34.9	10	9.2	1	0.9	109	100.0
Total	124	11.3	457	41.8	128	11.7	299	27.4	75	6.8	8	0.7	1091	100.0

TABLE 29

HOSPITAL BY

ROLE CONFLICT DUE TO INCONGRUENT WORK TASKS

Hospital	Strongly Agree		Agree		Un-decided		Disagree		Strongly Disagree		No Answer		Total	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Urban	76	10.7	280	39.5	113	16.0	210	29.7	24	3.4	5	0.7	708	100.0
Midland	6	5.1	35	29.7	17	14.4	53	44.9	6	5.1	1	0.8	118	100.0
Southern Municipal	17	10.9	47	30.1	31	19.9	53	34.0	7	4.5	1	0.6	156	100.0
Southern Religious	9	8.3	36	33.0	16	14.7	40	36.7	7	6.4	1	0.9	109	100.0
Total	108	9.8	398	36.4	177	16.2	356	32.6	44	4.0	8	0.7	1091	100.0

TABLE 30

HOSPITAL BY

ROLE CONFLICT DUE TO UNNECESSARY TASK PERFORMANCE

Hospital	Strongly Agree		Agree		Un-decided		Disagree		Strongly Disagree		No Answer		Total	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Urban	15	2.1	64	9.0	67	9.5	449	63.4	107	15.1	6	0.8	708	100.0
Midland	0	0.0	6	5.1	4	3.4	84	71.2	23	19.5	1	0.8	118	100.0
Southern Municipal	7	4.5	16	10.3	24	15.4	86	55.1	21	13.5	2	1.3	156	100.0
Southern Religious	3	2.8	12	11.0	11	10.1	67	61.5	16	14.7	0	0.0	109	100.0
Total	25	2.2	98	8.9	106	9.7	686	62.8	167	15.3	9	0.8	1091	100.0

TABLE 31

HOSPITAL BY

ROLE CONFLICT DUE TO POLICY INCOMPATIBILITY

Hospital	Strongly Agree		Agree		Un-decided		Disagree		Strongly Disagree		No Answer		Total	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Urban	33	4.7	240	33.9	98	13.8	261	36.9	73	10.3	3	0.4	708	100.0
Midland	5	4.2	20	17.0	15	12.7	61	51.7	15	12.7	2	1.7	118	100.0
Southern Municipal	7	4.5	33	21.2	25	16.0	67	42.9	23	14.7	1	0.6	156	100.0
Southern Religious	5	4.6	26	23.9	19	17.4	43	39.5	16	14.7	0	0.0	109	100.0
Total	50	4.5	319	29.2	157	14.3	432	39.5	127	11.6	6	0.5	1091	100.0

TABLE 32

HOSPITAL BY

ROLE CONFLICT DUE TO CONFLICTING GROUPS

Hospital	Strongly Agree N	Strongly Agree %	Agree N	Agree %	Un-decided N	Un-decided %	Disagree N	Disagree %	Strongly Disagree N	Strongly Disagree %	No Answer N	No Answer %	Total N	Total %
Urban	83	11.7	211	29.8	77	10.9	278	39.3	50	7.1	9	1.3	708	100.0
Midland	12	10.2	32	27.1	9	7.6	47	39.8	17	14.4	1	0.8	118	100.0
Southern Municipal	23	14.7	39	25.0	19	12.2	61	39.1	12	7.7	2	1.3	156	100.0
Southern Religious	8	7.3	28	25.7	23	21.1	37	33.9	11	10.1	2	1.8	109	100.0
Total	126	11.5	310	28.4	128	11.7	423	38.7	90	8.2	14	1.2	1091	100.0

TABLE 33

HOSPITAL BY

ROLE CONFLICT DUE TO CONTRADICTORY REQUESTS

Hospital	Strongly Agree		Agree		Un-decided		Disagree		Strongly Disagree		No Answer		Total	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Urban	82	11.6	326	46.0	69	9.7	186	26.3	39	5.5	6	0.8	708	100.0
Midland	10	8.5	44	37.3	12	10.2	43	36.4	8	6.8	1	0.8	118	100.0
Southern Municipal	16	10.3	62	39.7	19	12.2	46	29.5	9	5.8	4	2.6	156	100.0
Southern Religious	10	9.2	42	38.5	14	12.8	31	28.4	11	10.1	1	0.9	109	100.0
Total	118	10.8	474	43.4	114	10.4	306	28.0	67	6.1	12	1.0	1091	100.0

TABLE 34

HOSPITAL BY

ROLE CONFLICT DUE TO CONFLICTS IN TASK ACCEPTABILITY

Hospital	Strongly Agree		Agree		Un-decided		Disagree		Strongly Disagree		No Answer		Total	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Urban	70	9.9	323	45.6	93	13.1	187	26.4	27	3.8	8	1.1	708	100.0
Midland Southern	9	7.6	46	39.0	18	15.3	36	30.5	7	5.9	2	1.7	118	100.0
Municipal	14	9.0	55	35.3	30	19.2	52	33.3	4	2.6	1	0.6	156	100.0
Southern Religious	6	5.5	53	48.6	19	17.4	26	23.9	5	4.6	0	0.0	109	100.0
Total	99	9.0	477	43.7	160	14.6	301	27.5	43	3.9	11	1.0	1091	100.0

TABLE 35

HOSPITAL BY

TOTAL ROLE AMBIGUITY

Hospital	Low		Medium		High		No Answer		Total	
	N	%	N	%	N	%	N	%	N	%
Urban	310	43.8	337	47.6	57	8.1	4	0.6	708	100.0
Midland	59	50.0	55	46.6	4	3.4	0	0.0	118	100.0
Southern Municipal	71	45.5	68	43.6	17	10.9	0	0.0	156	100.0
Southern Religious	57	52.3	50	45.9	2	1.8	0	0.0	109	100.0
Total	497	45.5	510	46.7	80	7.3	4	0.3	1091	100.0

TABLE 36

HOSPITAL BY

ROLE AMBIGUITY ABOUT AUTHORITY

Hospital	Strongly Agree		Agree		Un-decided		Disagree		Strongly Disagree		No Answer		Total	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Urban Midland	100	14.1	391	55.2	152	21.5	46	6.5	17	2.4	2	0.3	708	100.0
Southern	19	16.1	67	56.8	18	15.3	11	9.3	3	2.5	0	0.0	118	100.0
Municipal Southern	20	12.8	86	55.1	34	21.8	11	7.1	5	3.2	0	0.0	156	100.0
Religious	14	12.8	63	57.8	24	22.0	7	6.4	0	0.0	1	0.9	109	100.0
Total	153	14.0	607	55.6	228	20.8	75	6.8	25	2.2	3	0.2	1091	100.0

TABLE 37

HOSPITAL BY

ROLE AMBIGUITY ABOUT GOALS

Hospital	Strongly Agree		Agree		Un-decided		Disagree		Strongly Disagree		No Answer		Total	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Urban	120	17.0	382	54.0	123	17.4	70	9.9	10	1.4	3	0.4	708	100.0
Midland	27	22.9	69	58.5	15	12.7	6	5.1	1	0.8	0	0.0	118	100.0
Southern Municipal	25	16.0	84	53.8	23	14.7	19	12.2	4	2.6	1	0.6	156	100.0
Southern Religious	29	26.6	64	58.7	8	7.3	6	5.5	2	1.8	0	0.0	109	100.0
Total	201	18.4	599	54.9	169	15.4	101	9.2	17	1.5	4	0.3	1091	100.0

TABLE 38

HOSPITAL BY ROLE AMBIGUITY ABOUT RESPONSIBILITIES

Hospital	Strongly Agree		Agree		Un-decided		Disagree		Strongly Disagree		No Answer		Total	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Urban	102	14.4	383	54.1	108	15.3	92	13.0	15	2.1	8	1.1	708	100.0
Midland	14	11.9	78	66.1	13	11.0	11	9.3	0	0.0	2	1.7	118	100.0
Southern Municipal	17	10.9	97	62.2	18	11.5	17	10.9	5	3.2	2	1.3	156	100.0
Southern Religious	16	14.7	67	61.5	15	13.8	9	8.3	2	1.8	0	0.0	109	100.0
Total	149	13.6	625	57.2	154	14.1	129	11.8	22	2.0	12	1.0	1091	100.0

TABLE 39

HOSPITAL BY

ROLE AMBIGUITY ABOUT EXPECTATIONS

Hospital	Strongly Agree		Agree		Un-decided		Disagree		Strongly Disagree		No Answer		Total	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Urban	172	24.3	430	60.7	56	7.9	45	6.4	4	0.6	1	0.1	708	100.0
Midland Southern	24	20.3	78	66.1	9	7.6	7	5.9	0	0.0	0	0.0	118	100.0
Municipal Southern	25	16.0	95	60.9	20	12.8	14	9.0	2	1.3	0	0.0	156	100.0
Religious	27	24.8	67	61.5	13	11.9	1	0.9	1	0.9	0	0.0	109	100.0
Total	248	22.7	670	61.4	98	8.9	67	6.1	7	0.6	1	0.1	1091	100.0

TABLE 40

HOSPITAL BY

ROLE AMBIGUITIES ABOUT TASK DUTIES

Hospital	Strongly Agree		Agree		Un-decided		Disagree		Strongly Disagree		No Answer		Total	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Urban	106	15.0	373	52.7	134	18.9	68	9.6	17	2.4	10	1.4	708	100.0
Midland	17	14.4	63	53.4	24	20.3	12	10.2	1	0.8	1	0.8	118	100.0
Southern Municipal	25	16.0	76	48.7	33	21.2	17	10.9	4	2.6	1	0.6	156	100.0
Southern Religious	16	14.7	72	66.1	16	14.7	2	1.8	2	1.8	1	0.9	109	100.0
Total	164	15.0	584	53.5	207	18.9	99	9.0	24	2.1	13	1.1	1091	100.0

TABLE 41

HOSPITAL BY

ROLE AMBIGUITY ABOUT TIME

Hospital	Strongly Agree N	Strongly Agree %	Agree N	Agree %	Un-decided N	Un-decided %	Disagree N	Disagree %	Strongly Disagree N	Strongly Disagree %	No Answer N	No Answer %	Total N	Total %
Urban	115	16.2	385	54.4	82	11.6	109	15.4	14	2.0	3	0.4	708	100.0
Midland	17	14.4	77	65.3	10	8.5	12	10.2	1	0.8	1	0.8	118	100.0
Southern Municipal	19	12.2	84	53.8	25	16.0	21	13.5	7	4.5	0	0.0	156	100.0
Southern Religious	17	15.6	71	65.1	10	9.2	10	9.2	1	0.9	0	0.0	109	100.0
Total	168	15.3	617	56.5	127	11.7	152	13.9	23	2.1	4	0.3	1091	100.0

TABLE 42

HOSPITAL BY

COMBINED SCORES FOR ROLE CONFLICT AND ROLE AMBIGUITY

Hospital	Low		Medium		High		No Answer		Total	
	N	%	N	%	N	%	N	%	N	%
Urban	354	50.0	277	39.1	71	10.0	6	0.8	708	100.0
Midland	74	62.7	39	33.1	4	3.4	1	0.8	118	100.0
Southern Municipal	86	55.1	51	32.7	18	11.5	1	0.6	156	100.0
Southern Religious	65	59.6	38	34.9	6	5.5	0	0.0	109	100.0
Total	579	53.0	405	37.1	99	9.0	8	0.7	1091	100.0

TABLE 43

HOSPITAL BY

BUREAUCRATIC HIERARCHY OF AUTHORITY

Hospital	Low		High		Undecided		Total	
	N	%	N	%	N	%	N	%
Urban	536	75.8	164	23.1	7	0.9	707	100.0
Midland	107	92.2	9	7.7	0	0.0	166	100.0
Southern Municipal	127	81.4	28	17.9	1	0.6	156	100.0
Southern Religious	93	85.3	13	11.9	3	2.7	109	100.0
Total	863	79.3	214	19.6	11	1.0	1088	100.0

TABLE 44

HOSPITAL BY

BUREAUCRATIC DIVISION OF LABOUR

Hospital	Low		High		Undecided		Total	
	N	%	N	%	N	%	N	%
Urban	569	80.4	129	18.2	9	1.2	707	100.0
Midland	102	86.4	16	13.5	0	0.0	118	100.0
Southern Municipal	123	78.8	29	18.5	4	2.5	156	100.0
Southern Religious	95	87.1	12	11.0	2	1.8	109	100.0
Total	889	81.5	186	17.0	15	1.3	1090	100.0

TABLE 45

HOSPITAL BY

BUREAUCRATIC RULES FOR INCUMBENTS

Hospital	Low		High		Undecided		Total	
	N	%	N	%	N	%	N	%
Urban	205	29.8	480	69.8	2	0.2	687	100.0
Midland	58	49.1	60	50.8	0	0.0	118	100.0
Southern Municipal	71	45.5	85	54.4	0	0.0	156	100.0
Southern Religious	55	46.2	64	53.7	0	0.0	119	100.0
Total	389	36.0	689	63.7	2	0.1	1080	100.0

TABLE 46

HOSPITAL BY

BUREAUCRATIC PROCEDURAL SPECIFICATIONS

Hospital	Low		High		Undecided		Total	
	N	%	N	%	N	%	N	%
Urban	476	67.3	229	32.3	2	0.2	707	100.0
Midland	49	72.0	18	26.4	1	1.4	68	100.0
Southern Municipal	109	69.8	46	29.4	1	0.6	156	100.0
Southern Religious	78	71.5	31	28.4	0	0.0	109	100.0
Total	712	68.4	324	31.1	4	0.3	1040	100.0

TABLE 47

HOSPITAL BY

BUREAUCRATIC IMPERSONALITY

Hospital	Low		High		Undecided		Total	
	N	%	N	%	N	%	N	%
Urban	560	79.2	130	18.3	17	2.4	707	100.0
Midland	105	88.9	10	8.4	3	2.5	118	100.0
Southern Municipal	131	83.9	19	12.1	6	3.8	156	100.0
Southern Religious	85	77.9	18	16.5	6	5.5	109	100.0
Total	881	80.8	177	16.2	32	2.9	1090	100.0

TABLE 48

HOSPITAL BY

BUREAUCRATIC TECHNICAL COMPETENCY

Hospital	Low		High		Undecided		Total	
	N	%	N	%	N	%	N	%
Urban	296	41.8	408	57.7	3	0,4	707	100.0
Midland	44	37.2	73	61.8	1	0.8	118	100.0
Southern Municipal	74	47.4	80	51.2	2	1.2	156	100.0
Southern Religious	51	46.7	51	46.7	7	6.4	109	100.0
Total	465	42.6	612	56.1	13	1.1	1090	100.0

TABLE 49

HOSPITAL BY

AGREEMENTS NEGOTIATION

Hospital	Low		High		Undecided		Total	
	N	%	N	%	N	%	N	%
Urban	256	36.5	444	63.3	1	0.1	701	100.0
Midland	45	38.7	71	61.2	0	0.0	116	100.0
Southern Municipal	80	51.6	75	48.3	0	0.0	155	100.0
Southern Religious	44	41.5	62	58.4	0	0.0	106	100.0
Total	425	39.4	652	60.4	1	0.1	1078	100.0

TABLE 50

HOSPITAL BY

RULES NEGOTIATION

Hospital	Low		High		Undecided		Total	
	N	%	N	%	N	%	N	%
Urban	532	75.7	161	22.9	9	1.2	702	100.0
Midland	91	77.1	26	22.0	1	0.8	118	100.0
Southern Municipal	114	73.5	35	22.5	6	3.8	155	100.0
Southern Religious	83	78.3	23	21.6	0	0.0	106	100.0
Total	820	75.8	245	22.6	16	1.4	1081	100.0

TABLE 51

HOSPITAL BY

COMMITTEE NEGOTIATION

Hospital	Low		High		Undecided		Total	
	N	%	N	%	N	%	N	%
Urban	360	51.1	233	33.0	111	15.7	704	100.0
Midland	61	51.6	40	33.8	17	14.4	118	100.0
Southern Municipal	75	47.7	52	33.1	30	19.1	157	100.0
Southern Religious	55	50.9	30	27.7	23	21.2	108	100.0
Total	551	50.6	355	32.6	181	16.6	1087	100.0

TABLE 52

HOSPITAL BY

TASK NEGOTIATION

Hospital	Low		High		Undecided		Total	
	N	%	N	%	N	%	N	%
Urban	521	74.3	175	24.9	5	0.7	701	100.0
Midland	100	81.9	18	14.7	4	3.2	122	100.0
Southern Municipal	119	77.7	32	20.9	2	1.3	153	100.0
Southern Religious	78	67.8	26	22.6	11	9.5	115	100.0
Total	818	74.9	251	23.0	22	2.0	1091	100.0

TABLE 53

HOSPITAL BY

INTER-DEPARTMENTAL NEGOTIATION

Hospital	Low		High		Undecided		Total	
	N	%	N	%	N	%	N	%
Urban	296	42.7	394	56.9	2	0.2	692	100.0
Midland	56	47.0	60	50.4	3	2.5	119	100.0
Southern Municipal	74	51.7	68	47.5	1	0.6	143	100.0
Southern Religious	48	45.2	57	53.7	1	0.9	106	100.0
Total	474	44.7	579	54.6	7	0.6	1060	100.0

APPENDIX B

HOSPITAL ORGANIZATION QUESTIONNAIRE

Hospital Organization Study

Dear Sir or Madam:

I am asking you to participate in a study of hospitals in the province of Alberta. The purpose of this questionnaire is to study selected aspects of the work situations of the people who provide the services and care for the sick and injured in Alberta hospitals.

Procedure

Please answer each of the questions either from your own observations or what you feel to be the actual situation in your case.

Because you know best what is happening, I would appreciate any additional comments you might have, either about the questionnaire or your own work situation. I invite you to write your comments wherever you feel necessary.

With this questionnaire you have received an extra envelope. This envelope is addressed to the researcher. When you have completed your questionnaire, place it in the self-addressed envelope, SEAL THE ENVELOPE SECURELY, and return it to the place designated below.

Please DO NOT SIGN your name to ANY part of this questionnaire. THIS IS TO ENSURE YOUR CONFIDENTIALLY. No one other than the researcher will see your answers.

THE SUCCESS OF THIS PROJECT DEPENDS UPON YOUR COMPLETION AND RETURN OF THIS QUESTIONNAIRE.

THANK YOU FOR YOUR PATIENCE AND COOPERATION.

Please return your
questionnaire to:

Sincerely
G. DEWEY EVANS
Department of Sociology
University of Alberta

Personnel Questionnaire

IBM NO. ______________________

NOTE: The numbers above and the column numbers are for IBM purposes only. Please ignore them.

9-10 In what department of the hospital do you work?

____

11-12 What is your present job at the hospital?

____

13 How long have you held your present job?

1 ______ six months or less
2 ______ between six months and one year
3 ______ between one year and two years
4 ______ between two years and five years
5 ______ between five years and ten years
6 ______ ten years or more

14 How long have you worked at this hospital?

1 ______ six months or less
2 ______ between six months and one year
3 ______ between one year and two years
4 ______ between two years and five years
5 ______ between five years and ten years
6 ______ ten years or more

15 What shift are you now on?

1 ______ day
2 ______ evening
3 ______ night
4 ______ rotating shift

16 Do you work full-time at the hospital?

1 ______ full-time
2 ______ part-time

17 What sex are you?

1 ______ female
2 ______ male

18 What formal education have you had?

1 ______ one to six years
2 ______ seven to twelve years
3 ______ high school graduate
4 ______ some college, but not completed
5 ______ college or university graduate
6 ______ graduate degree (eg. M.A., M.S., Ph.D., etc.)
7 ______ two year nursing program
8 ______ three year nursing program
9 ______ other, please specify ______________________________

19 Are you licensed or certified to practice by some group or association?

1 _____ no (If no, please skip to question 21)

2 _____ yes ⟶ What license or certificate do you hold?

20-21 ______________________________

From what association have you received your license or certificate to practice?

22-23 ______________________________

24 How many professional organizations do you belong to?

1 _____ not a member of any (If not a member skip to question 27)

2 _____ one

3 _____ two

4 _____ three

5 _____ four or more

How often do you attend the meetings of these professional organizations to which you belong?

1 _____ there are no meetings

2 _____ never

3 _____ once a year

4 _____ twice a year

5 _____ three times a year

6 _____ four times or more a year

25 How often do you read the journals put out by the association(s) to which you belong?

1 _____ there are no journals

2 _____ never or rarely

3 _____ sometimes

4 _____ regularly

27 Choose three persons from the list below, whose judgement counts most when your work performance is evaluated, and rank them from 1-3 in importance.

1 _____ patient's relatives

2 _____ the head of my department, because a superior in my profession

3 _____ patients

4 _____ supervisor of section

5 _____ the head of my department, because my administrative superior

6 _____ all visitors to the hospital

7 _____ people in the same profession as I am

8 _____ my own

9 _____ personnel office

28 Different people want different things out of their jobs. Please rank in importance, from 1-3, the three things you consider MOST important in your job.

1 _____ job security

2 _____ having the necessary materials and space to complete my tasks

3 _____ opportunity to help others

4 _____ steady income

5 _____ performing a socially necessary and useful job

6 _____ learning opportunity

7 _____ opportunity to make decisions based on my own judgement

8 _____ promotion opportunities

9 _____ other, please specify ______________________________

For each of the following questions, BOX the percent that most closely approximates the situation as you see it.

For example, in answer to the question "How often do you talk to your co-workers about job related activities?", you might feel that the answer was about 60 percent. You would then box "60%", as indicated in the example below.

EXAMPLE

always — never
100% 80% [✓ 60%] 40% 20% 0%
: : : : : : : : : : :

30 **Think of all the ways decisions are made in your department. Out of these different ways, how often do departmental members meet in committees to make decisions on departmental matters?**

always — never
100% 80% 60% 40% 20% 0%
: : : : : : : : : : :

31 **How often are solutions to departmental problems reached by the departmental personnel discussing the problems among themselves and deciding what to do?**

always — never
100% 80% 60% 40% 20% 0%
: : : : : : : : : : :

32 **How frequently have you been assigned to do a job only to find that someone else was also assigned to do the very same thing?**

always — never
100% 80% 60% 40% 20% 0%
: : : : : : : : : : :

33 **How frequently is work time lost because there is poor scheduling and planning in your department?**

always — never
100% 80% 60% 40% 20% 0%
: : : : : : : : : : :

34 **How often do you find yourself doing work that other people in your department should be doing?**

always — never
100% 80% 60% 40% 20% 0%
: : : : : : : : : : :

Please answer the following TWO questions only if there is shift work in your department.

35 **When you come to work, how difficult is it for you to find out what happened on the job since you were last there?**

difficult — easy
100% 80% 60% 40% 20% 0%
: : : : : : : : : : :

36 **How often do you feel that people from the previous shift left you with unfinished work or problems they should have handled during their own shift?**

always — never
100% 80% 60% 40% 20% 0%
: : : : : : : : : : :

37 **How satisfied are you with the working conditions which accompany your job?**

completely satisfied — completely unsatisfied
100% 80% 60% 40% 20% 0%
: : : : : : : : : : :

38 How satisfied are you with the chances for promotion in your job?

completely satisfied					completely unsatisfied
100%	80%	60%	40%	20%	0%

39 How satisfied are you with the wages or salary that you receive?

completely satisfied					completely unsatisfied
100%	80%	60%	40%	20%	0%

40 How satisfied are you with the working relations you have with your fellow workers?

completely satisfied					completely unsatisfied
100%	80%	60%	40%	20%	0%

41 How satisfied are you with the supervision that you receive?

completely satisfied					completely unsatisfied
100%	80%	60%	40%	20%	0%

42 How satisfied are you with the freedom to make your own decisions about your work?

completely satisfied					completely unsatisfied
100%	80%	60%	40%	20%	0%

44 When one of the persons at your level doesn't know how to do a job, how frequently does your immediate supervisor have the "job know-how" to explain how it is done?

always					never
100%	80%	60%	40%	20%	0%

45 How much does your immediate supervisor know about doing each of the jobs in your area?

everything					nothing
100%	80%	60%	40%	20%	0%

46 How much does your immediate supervisor know about the equipment you are responsible for?

everything					nothing
100%	80%	60%	40%	20%	0%

47 Do you feel your immediate supervisor will go to bat or stand up for you?

always					never
100%	80%	60%	40%	20%	0%

48 In solving the job problems, does your immediate supervisor try to get the ideas and opinions of you and the other people in your department?

always					never
100%	80%	60%	40%	20%	0%

49 To what degree do you feel your immediate supervisor appreciates your work?

completely 100%		80%		60%		40%		20%		not at all 0%
:	:	:	:	:	:	:	:	:	:	:

50 How free do you feel to discuss important things about your job with your immediate supervisor?

completely free 100%		80%		60%		40%		20%		not at all 0%
:	:	:	:	:	:	:	:	:	:	:

51 How much help and support do you feel you get from your immediate supervisor when you really need it?

all I need 100%		80%		60%		40%		20%		none 0%
:	:	:	:	:	:	:	:	:	:	:

56 In general, how would you rate your department or work group in terms of the following items? Please check only one space per item. For example, if you felt that relations within your department were only somewhat friendly you might place an X in the space as illustrated.

EXAMPLE

	8	7	6	5	4	3	2	1	
friendly							X		unfriendly

Please remember to check an answer for **each** item below.

	8	7	6	5	4	3	2	1	
friendly									unfriendly
accepting									rejecting
satisfying									frustrating
enthusiastic									unenthusiastic
productive									nonproductive
warm									cold
cooperative									uncooperative
supportive									hostile
interesting									boring
successful									unsuccessful

Below are a number of statements which people have used to describe how they felt about their job and the demands placed upon them in their job. Please indicate how well these statements describe your own feelings about your job. There are five possible answers to each question.

They are: STRONGLY AGREE (SA) AGREE (A) UNDECIDED (U) DISAGREE (DA) STRONGLY DISAGREE (SDA)

Please circle the answer which most closely approximates how you feel.

57 I feel certain about how much authority I have.	SA 1	A 2	U 3	DA 4	SDA 5
58 There are clear, planned goals and objectives for my job.	SA 1	A 2	U 3	DA 4	SDA 5
59 I have to do things that I feel should be done differently.	SA 1	A 2	U 3	DA 4	SDA 5
60 I know that my time is divided properly in order to get my job done.	SA 1	A 2	U 3	DA 4	SDA 5
61 I receive assignments without the personnel or equipment to complete it.	SA 1	A 2	U 3	DA 4	SDA 5

62 I know what all my responsibilities are.	SA 1	A 2	U 3	DA 4	SDA 5
63 I have to buck a rule or policy in order to carry out an assignment sometimes.	SA 1	A 2	U 3	DA 4	SDA 5
64 I work with two or more groups who operate quite differently.	SA 1	A 2	U 3	DA 4	SDA 5
65 I know exactly what is expected of me.	SA 1	A 2	U 3	DA 4	SDA 5
66 I receive contradictory requests from two or more people sometimes.	SA 1	A 2	U 3	DA 4	SDA 5
67 My duties have been clearly explained to me.	SA 1	A 2	U 3	DA 4	SDA 5
68 I receive my assignments without adequate resources and material to do them.	SA 1	A 2	U 3	DA 4	SDA 5
69 I do things that are apt to be accepted by one person but not by others.	SA 1	A 2	U 3	DA 4	SDA 5
70 I work on unnecessary tasks sometimes.	SA 1	A 2	U 3	DA 4	SDA 5

CARD II

Each department relies on other departments, to some degree, to provide the necssary services, facilities or information to do its own work.

To what extent does your department depend on each of the departments listed below, in order to do your department's work properly?

Please be sure to check an answer for each department in the hospital, other than your own. Draw a line through your own department if it is listed.

DEPARTMENT	HIGHLY DEPENDENT	MODERATELY DEPENDENT	SLIGHTLY DEPENDENT	NOT DEPENDENT
13 Radiology				
14 Admissions				
15 Laboratory				
Nursing Personnel in:				
16 a. Medical Section				
17 b. Surgical Section				
18 c. Operating Room				
19 d. Pediatrics				
20 e. Obstetrics and Gynecology				
21 Medical Staff				
22 Central Supply Room				
23 Emergency				
24 Outpatient				
25 Pharmacy				
26 Business Office (Administration)				
27 Dietary				
28 Stores				
29 Maintenance				
30 Housekeeping				
31 Social Service				
32 Personnel Office				
33 Physical Medicine (Physio-therapy)				
34 Medical Records				
35 Laundry				

For each of the statements below, please indicate how well the statement describes your department. There are five possible answers for each statement. They are: VERY WELL (VW) FAIRLY WELL (FW) POORLY (P) NOT AT ALL (NA) and UNDECIDED (U)

For each statement circle the answer which you feel most closely describes your department.

36 I feel that I am my own boss in most matters.	VW 1	FW 2	P 3	NA 4	U 5
37 People here do the same job in the same way every day.	VW 1	FW 2	P 3	NA 4	U 5
38 The hospital has a manual of rules and regulations to be followed.	VW 1	FW 2	P 3	NA 4	U 5
39 Whatever situation arises, we have procedures to follow in dealing with it.	VW 1	FW 2	P 3	NA 4	U 5
40 In order to get a promotion, you have to "know somebody".	VW 1	FW 2	P 3	NA 4	U 5
41 No one can get necessary supplies without special permission.	VW 1	FW 2	P 3	NA 4	U 5
42 Everyone has a specific job to do.	VW 1	FW 2	P 3	NA 4	U 5
43 Employees are often left to their own judgement as to how to handle various problems.	VW 1	FW 2	P 3	NA 4	U 5
44 People who have contact with patients or visitors are taught the correct way to greet and talk with them.	VW 1	FW 2	P 3	NA 4	U 5
45 Applicants must be qualified before they are hired here.	VW 1	FW 2	P 3	NA 4	U 5
46 Everyone here has a superior to whom he regularly reports.	VW 1	FW 2	P 3	NA 4	U 5
47 The employees are constantly being checked upon for rule violations.	VW 1	FW 2	P 3	NA 4	U 5
48 How things are done around here is left pretty much up to the person doing the work.	VW 1	FW 2	P 3	NA 4	U 5
49 The time for coffee breaks is strictly regulated.	VW 1	FW 2	P 3	NA 4	U 5
50 People are not promoted simply because they have "pull".	VW 1	FW 2	P 3	NA 4	U 5
51 People always get their orders from someone higher up.	VW 1	FW 2	P 3	NA 4	U 5
52 Most jobs have something new happening every day.	VW 1	FW 2	P 3	NA 4	U 5
53 Management here sticks pretty much to themselves.	VW 1	FW 2	P 3	NA 4	U 5
54 People working here usually find their jobs to be very monotonous.	VW 1	FW 2	P 3	NA 4	U 5
55 Most people here make their own rules on the job.	VW 1	FW 2	P 3	NA 4	U 5
56 Going through the proper channels is constantly stressed.	VW 1	FW 2	P 3	NA 4	U 5
57 We are encouraged not to become overly friendly with outsiders.	VW 1	FW 2	P 3	NA 4	U 5

	VW	FW	P	NA	U
58 The hospital keeps a record of everyone's job performance.	1	2	3	4	5
59 A person who wants to make his own decisions would quickly become discouraged here.	1	2	3	4	5
60 We are to follow strict operating procedures all the time.	1	2	3	4	5
61 We are expected to be courteous, but reserved, at all times.	1	2	3	4	5
62 Even small matters have to be referred to someone higher up for a final answer.	1	2	3	4	5
63 We usually work under the same circumstances from day to day.	1	2	3	4	5
64 There is no rules manual.	1	2	3	4	5
65 Whenever we have a problem, we are supposed to go to the same person for an answer.	1	2	3	4	5
66 A lot of people here get together over weekends.	1	2	3	4	5
67 Employees are periodically evaluated to see how well they are doing.	1	2	3	4	5

CARD III

In your experience while working at this hospital, how often do problems such as lack of cooperation, interference in work activities, poor planning or delays of services tend to occur between your department and the departments that are listed below?

Please indicate as well, how much contact your department has with each of the other departments.

Please circle the number that most closely approximates the situation as you see it. Remember to answer both parts of the question.

DEPARTMENT	AMOUNT OF CONTACT				EXTENT TO WHICH PROBLEMS OF LACK OF COOPERATION, INTERFERENCE, DELAYS OR POOR PLANNING TEND TO ARISE.					
	FREQUENT 1	MODERATE 2	LITTLE 3	NONE 4	ALWAYS					NEVER
13 Radiology	1	2	3	4	100%	80%	60%	40%	20%	0%
14 Admissions	1	2	3	4	100%	80%	60%	40%	20%	0%
15 Laboratory	1	2	3	4	100%	80%	60%	40%	20%	0%
Nursing Personnel in:										
16 a. Medical Section	1	2	3	4	100%	80%	60%	40%	20%	0%

	AMOUNT OF CONTACT				EXTENT TO WHICH PROBLEMS OF LACK OF COOPERATION, INTERFERENCE, DELAYS OR POOR PLANNING TEND TO ARISE.					
DEPARTMENT	FREQUENT 1	MODERATE 2	LITTLE 3	NONE 4	ALWAYS					NEVER
17 b. Operating Room	1	2	3	4	100%	80%	60%	40%	20%	0%
18 c. Surgical Section	1	2	3	4	100%	80%	60%	40%	20%	0%
19 d. Pediatrics	1	2	3	4	100%	80%	60%	40%	20%	0%
20 e. Obstetrics and Gynecology	1	2	3	4	100%	80%	60%	40%	20%	0%
21 Medical Staff	1	2	3	4	100%	80%	60%	40%	20%	0%
22 Central Supply Room	1	2	3	4	100%	80%	60%	40%	20%	0%
23 Emergency	1	2	3	4	100%	80%	60%	40%	20%	0%
24 Outpatient	1	2	3	4	100%	80%	60%	40%	20%	0%
25 Pharmacy	1	2	3	4	100%	80%	60%	40%	20%	0%
26 Business Office	1	2	3	4	100%	80%	60%	40%	20%	0%
27 Dietary	1	2	3	4	100%	80%	60%	40%	20%	0%
28 Stores	1	2	3	4	100%	80%	60%	40%	20%	0%
29 Maintenance	1	2	3	4	100%	80%	60%	40%	20%	0%
30 Housekeeping	1	2	3	4	100%	80%	60%	40%	20%	0%
31 Social Service	1	2	3	4	100%	80%	60%	40%	20%	0%
32 Personnel Office	1	2	3	4	100%	80%	60%	40%	20%	0%
33 Physical Medicine	1	2	3	4	100%	80%	60%	40%	20%	0%
34 Medical Records	1	2	3	4	100%	80%	60%	40%	20%	0%
35 Laundry	1	2	3	4	100%	80%	60%	40%	20%	0%

Since the work situations of people in different jobs varies from person to person, we would like to determine some of your work experiences. In terms of your own personal experience, how often would the following sentences apply to your work situation as you experience it?

There are five possible answers. They are: VERY OFTEN (VO) FAIRLY OFTEN (FO) OCCASIONALLY (O) NOT AT ALL (NA) and UNDECIDED (U)

Circle the answer which you feel most closely approximates your work situation.

36 With some people, everyone knows what they expect to have done without them having to give instructions every time.	VO 1	FO 2	O 3	NA 4	U 5
37 When a situation arises where no rule applies, the people here can agree on their own informal rules without having to go to the supervisor all the time.	VO 1	FO 2	O 3	NA 4	U 5
38 Interdepartmental committees determine the procedures people from different departments are to follow when working together.	VO 1	FO 2	O 3	NA 4	U 5
39 When someone wants something done in a certain way, they may get others to do it that way because "it is in the best interest of the patient or the hospital".	VO 1	FO 2	O 3	NA 4	U 5
40 When a new situation arises, people discuss with each other what each person should do.	VO 1	FO 2	O 3	NA 4	U 5
41 When committees meet, committee members supply the facts about the problem and the chairman makes the decision.	VO 1	FO 2	O 3	NA 4	U 5
42 Where rules are inappropriate, people have to agree among themselves on what should be done.	VO 1	FO 2	O 3	NA 4	U 5
43 For people to have the necessary time, and equipment to do a job, it is necessary to persuade others that these things are necessary.	VO 1	FO 2	O 3	NA 4	U 5
44 People can use the rules to avoid doing something someone asks them to do.	VO 1	FO 2	O 3	NA 4	U 5
45 To get the job done properly, it may be necessary to get others to agree to do things differently than usual.	VO 1	FO 2	O 3	NA 4	U 5
46 If there is no rule to specify what is to be done, the supervisor or head decides.	VO 1	FO 2	O 3	NA 4	U 5
47 Some people who have worked here for a long time have a pretty good idea of what the others expect them to do.	VO 1	FO 2	O 3	NA 4	U 5
48 Committee meetings are only places where a formal rule is told to everyone at the same time.	VO 1	FO 2	O 3	NA 4	U 5
49 Determining who should do what is a daily concern.	VO 1	FO 2	O 3	NA 4	U 5
50 When a person is new here, he has to learn how people do things, besides learning the rules.	VO 1	FO 2	O 3	NA 4	U 5
51 Cooperation between the people from different departments depends more on informal agreements than on strict rules.	VO 1	FO 2	O 3	NA 4	U 5
52 People from different departments who have to work together, make their own arrangements with each other in order to get the work done properly and on time.	VO 1	FO 2	O 3	NA 4	U 5
53 When a situation arises where a rule just doesn't fit, a temporary agreement between the persons involved is necessary so that the work is not delayed.	VO 1	FO 2	O 3	NA 4	U 5
54 When committee meetings take place, there is much discussion and compromise before any decision is made.	VO 1	FO 2	O 3	NA 4	U 5
55 If people from different departments have worked together for a long time, they know what is expected of each other.	VO 1	FO 2	O 3	NA 4	U 5

56 Even where there are rules, cooperation between departments depends on the working arrangements people have made with each other.	VO 1	FO 2	O 3	NA 4	U 5
57 When people must work together in teams, they must agree on what each person is to do.	VO 1	FO 2	O 3	NA 4	U 5
58 When someone wants to introduce a new procedure or rule, they talk to the people involved to get them to accept it.	VO 1	FO 2	O 3	NA 4	U 5
59 The people here work out their own arrangements about sharing work loads.	VO 1	FO 2	O 3	NA 4	U 5
60 People make informal rules among themselves in order to get the job done.	VO 1	FO 2	O 3	NA 4	U 5
61 Teamwork depends on a minimum of give and take between team members.	VO 1	FO 2	O 3	NA 4	U 5

THANK YOU VERY MUCH FOR YOUR HELP AND COOPERATION IN THIS STUDY.
PLEASE REMEMBER TO PLACE THIS QUESTIONNAIRE IN THE ENCLOSED ENVELOPE AND SEAL IT.

APPENDIX C

AREAS OF HOSPITAL OPERATION FORM

AREAS OF HOSPITAL OPERATION

Below are listed twelve problem areas in the hospital. Please indicate how demanding and how critical you feel each of the areas is in the operation of the hospital, by ranking them from 1 to 12. Consider "1" to be the highest rank or the most important or demanding in time. If you feel that some areas are equally critical or demanding in time, assign the areas you feel to be equivalent the same rank.

	HOW DEMANDING OF YOUR TIME	HOW CRITICAL IN THE OPERATION OF THE HOSPITAL
1. Administrative department heads and departmental functioning, including nursing and special services.		
2. Business and financial management.		
3. Community relationships, including relations with other hospitals, with local health and welfare agencies and public relations in general.		
4. Education programs.		
5. External controls (governmental regulations and so forth).		
6. Governing Board.		
7. Legal aspects and litigation.		
8. Medical staff.		
9. Personnel management and employee relations.		
10. Physical plant and equipment including construction.		
11. Planning patient care services and facilities.		

12. Research programs. ______________ ____________________

APPENDIX D

ROLES CONCEPTION QUESTIONNAIRE

Instructions for completing the Roles Conception Questionnaire

On the following pages are a series of decision situations that could arise in a general hospital. Please indicate the kind of involvement you think the Board of Trustees, the Medical Staff and the Administrator should have in each of the situations described in the questionnaire.

There are four possible answers. They are:

SPD---Should have the Power to Decide

SR----Should be able to make Recommendations.

MMNO--May or May Not express an Opinion.

ANI---Absolutely should Not be Involved.

For example, if in some situation you felt that the Medical Staff and the Board of Trustees should have the power to make the decision, you would place an X or check beside each group under the category "Should have the Power to Decide" (SPD). At the same time, if you felt that the Administrator "Should be able to make Recommendations" (SR), but should not make the decision you would then place an X or check in the appropriate space across from the title Administrator.

Thus your answer would look like the following example:

	SPD	SR	MMNO	ANI
Board of Trustees	X			
Medical Staff	X			
Administrator		X		

ROLES CONCEPTION

PLEASE BE SURE TO CHECK AN ANSWER FOR EACH OF THE THREE GROUPS IN EACH QUESTION

1. When nursing staff and other personnel request raises in salary and wages.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

2. When a decision must be made to share laundry facilities with another hospital in a city or region.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

3. When a decision must be made to join a group purchasing plan.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

4. When an appointment for a Director of Nursing must be made.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

5. When a set of Medical Staff by-laws must be developed for a general hospital.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

6. When decisions must be made about purchasing a major piece of equipment considered necessary for good patient care.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

7. When the drug variance is higher than standards considered acceptable.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

8. When policy regarding admission practices must be made.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

9. When disagreements arise between the head of a clinical department and the head of a service department.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

10. When equipment is not being utilized to the capacity that had been estimated when purchased, thereby raising the cost of operation and requiring some adjustment in use.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

11. When an appointment for a hospital administrator is to be made prior to the retirement of a present incumbent.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

12. When a decision must be made to share medical service facilities with another hospital.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

13. When a decision to seek an accreditation survey must be made and it is financially possible.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff	✓			
Administrator				

14. When a decision must be made to share the services and costs of professional service personnel, such as a pathologist, with another hospital.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

15. When a decision must be made to resolve a disagreement between the purchasing agent and the head of a Clinical department about the possibility that a similar supply item might be equally effective at less cost.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

16. When a budgetary control system for departments must be set up.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

17. When a decision to prepare a regular monthly service report for physicians' information must be made.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

18. When a decision to suspend admitting privileges of a physician due to incomplete medical records must be made.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

19. When a Joint Conference Committee meets to hear the appeal of a staff member who has not been recommended for reappointment.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

20. When a decision to hire a Personnel Director is to be made.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

21. When a decision to participate in the Professional Activity Study must be made.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

22. When a decision whether or not to introduce a "unit-dose-packaging system" must be made.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

23. When a "value-analysis" of certain standardized medical materials must be made.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

24. When the services of a medical service department have been utilized in such a way as to exceed the operating budget and a decision as to the remedial action to take must be made.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

25. When a decision must be made as to what health needs of the community a hospital should and should not provide.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

26. When a decision must be made as to what insurance the hospital is to carry and for what purposes.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

27. When a decision is to be made about what policy to follow regarding visitor hours.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

28. When a decision is to be made as to what policy to follow concerning what should be released to the news media and who should be allowed to release information.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

29. When a Medical Record librarian is to be selected and hired.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

30. When a decision as to what policy to follow and the rules to be implemented has to be made concerning the suspension or retirement of physicians from the Medical Staff.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

31. When a grievance is made by the members of a hospital's service department concerning the head of that department.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

32. When a lawsuit is being brought against the hospital for negligence on the part of hospital personnel and some course of action must be determined.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

33. When a decision is to be made as to hiring a qualified person for the position of Medical Director and what his duties will be.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

34. When the operating budget for the next fiscal year must be determined.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

35. When complaints have been received about the food service provided.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

36. When conflicts between members of the Medical Staff and hospital personnel arise.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

37. When a decision must be made about personnel practices when wages and salaries are rising but funds for operating the hospital are not.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

38. When a decision about the location and sharing of costs and facilities for an outpatient clinic among the hospitals of a community must be made.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

39. When the Medical Staff by-laws must be reviewed and revised.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

40. When connections with other hospitals and local health and welfare agencies are to be made to promote efficient utilization and better planning of health care facilities.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

41. When decisions as to the scheduling of operating room hours are to be made.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

42. When personnel who have served the hospital for a long time are to be honored.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

43. When a disagreement between the Nursing Director and the head of a clinical department has arisen.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

44. When policy and procedures must be developed concerning intern and residency programs.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

45. When employee turnover is high in a nursing unit and some action must be taken.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

46. When problems of coordinating the services provided by the hospital service departments arise.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

47. When a decision must be made about whether or not to provide bed space for a proposed research project when bed space is limited.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

48. When it is felt that the emergency department of a hospital is overburdened with nonemergency cases and some action must be taken to relieve the pressure.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

49. When a decision whether to engage a hospital consultant in housekeeping and infection must be made.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

50. When planning for additional patient care services is felt to be necessary.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

51. When a decision whether or not to renovate the existing plant must be made.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

52. When procedural rules and policies affecting the working relationships between nursing departments and service departments must be changed.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

53. When procedures and policies regarding the use of disposable items must be developed.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

54. When adequate procedures for the disposal of kitchen and laboratory waste must be decided upon.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

55. When the hours of an outpatient clinic are to be decided upon.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

56. When personnel policies are to be determined and decided upon.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

57. When a community relations program is to be set up and decided upon.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

58. When disagreements between the heads of clinical departments arise.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

59. When accreditation status has been lost and the remedial actions to take are to be determined.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

60. When a decision must be made to resolve a disagreement between the purchasing agent and the head of a Service department regarding the possibility that a similar supply item might be equally effective at less cost.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

61. When dissatisfaction with the head of a clinical department is expressed by members of the Medical Staff.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

62. When problems of coordinating the services of the clinical departments arise.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

63. When it is felt that the Medical Staff organization should be reviewed and changes should be made.

	SPD	SR	MMNO	ANI
Board of Trustees				
Medical Staff				
Administrator				

APPENDIX E

THE INTERVIEW SCHEDULE

APPENDIX E

Control-Coordination

A lot of the hospital administration journals and textbooks emphasize the need to achieve coordination and control in hospitals. While they sometime give illustrations, they are never explicit about the techniques practicing administrators actually do use to achieve coordination and control.

1. Do you feel control and coordination are important objectives to achieve?

   Probe for relative importance.
   1a. Are there other objectives that are more important?
   1b. How much time do you spend, on the average, in achieving coordination and control?

2. Could you describe for me the means or methods you use to obtain control and coordination?

For Dept. Heads Ask

What means do you use to direct or regulate your department's affairs and to coordinate its services and activities with those of other departments?

3. What use do you make of written reports, statistical indices, committee reports and the like?

4. In general, in what way is the written word used as opposed to the verbal?

5. Excluding the Medical Staff committees for the moment, how are committees used in the management of the hospital?

6. Are these committees or meetings primarily concerned with interdepartmental matters or with problems departments heads have that are unique to each department as well?

   ...If interdepartmental primarily, how are the unique problems of departments handled and with whom?

7. Are these meetings regularly scheduled?

8. Who attends these meetings?

Ask the following questions if administrator, assistant administrator, or medical director (or his equivalent).

9. How does the Medical Advisory Committee and related staff committee operate and fit into the operation of the hospital?

10. Is the Medical Advisory Committee the final judge of what committee recommendations should be acted upon or sent to the board?

11. Are committee recommendations generally accepted by the Medical Advisory Committee?

12. What happens when they are not?

13. Are there any circumstances where the Medical Advisory Committee would directly handle some problem itself?

14. What functions does the Joint Conference Committee serve?

14.a) (If Liaison)...Do you mean it makes recommendations to the board and Medical Advisory Committee to act upon?

15. With what kinds of problems or issues is the Joint Conference Committee generally concerned?

16. Does this committee meet regularly or only when it is felt necessary?

16.a) (If Necessary)...what do you mean by necessary?

Ask only if administrator or assistant administrator.

17. How do you view your (the administrator's) role as an ex officio member of the board and Medical Staff Meetings?

18. Of what importance is this particular role to you (the administrator) in the administration of the hospital?

All respondents

19. Are there any issues or concerns which seem to constantly arise between:

    1. Medical Staff and the Board
    2. Medical Staff and Nursing
    3. Administration and the Medical Staff
    4. Administration and Nursing
    5. Administration and the Board

20. In what ways do you feel that the attitude of Management set the tone for the whole hospital?

21. What would you say to the arguement that size makes a difference in the way a hospital is run and the kinds of relationships that exist in the hospital?

Interdepartmental Conflict

1. How are problems between departments resolved when they do arise?

2. Who is involved in this? Heads and/or personnel?

3. Are departmental personnel ever involved in any way in resolving such problems or is this something the heads of departments generally handle?

4. If some problem between departments cannot be resolved at the department head level, what is the next step in resolving such problems?

5. In what ways do the routines and procedures of each department affect the working relationships between departments?

6. If a department wished to change its procedures or routines for some reason, what considerations and steps would be taken in changing them, insofar as this would affect other departments?

7. How are conflicts, within departments, over task assignments generally handled?

Policy, Procedure

1. How do you determine the need for policy or changes in policy and procedures?

2. What steps do you take once it has been determine such a need exists?

3. Are departmental personnel involved in this in any way?

4. Are there any persons in particular that you work with to promote the acceptance of policy or procedural changes?

Ask only if administrator, assistant or medical director

5. Is there any person or persons you work with in particular

when decisions or policies are made that affect the Medical Staff?

6. What steps are taken whenever someone or a group of persons disagree with policy or established procedures?

Quality of Care

1. In what ways are you involved as.................in ensuring that the quality of patient care is up to standards and in the improvement of these standards?

Ask the following only if administrator, assistant administrator, medical director.

2. How does the organization of Medical Staff committees function in the maintenance of standards of care?

3. What problems do you encounter in ensuring that the staff organization functions properly?

4. What steps would you take if you felt that improvements in the staff organization were necessary?

5. Besides the Medical Staff organization, what other persons in the hospital are relied on for ensuring that patient care is up to established standards?

Include Nursing Director

6. How does the quality of nursing care and professional services affect the relationship between the medical staff and administration?

7. What steps would be taken if there were complaints by the medical staff about the quality of nursing care or vice versa.

Standards of Care

1. How are the standards of care established by your hospital being affected by the present system of financing health care?

2. What do you think will have to be done about the bind hospitals are finding themselves in with limited budgets

and rising personnel costs?

3. What steps do you think are necessary to take, both within and outside the hospital, in your capacity as............. to maintain standards?

Externalized Duties

1. Many of the Hospital Administration manuals often discuss the need for administrators to provide leadership to the board and the community, as well as within the hospitals? Unfortunately, they are never too clear by what they mean by this or what is involved. Would you clarify this using yourself as an example?